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# ROYAL COMMISSION ON HEALTH SERVICES

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing held  
in Ottawa, Ontario, on the 19th  
day of March, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Dr. C.L. STRACHAN

Dr. ARTHUR F. VAN WART

Mr. M. WALLACE McCUTCHEON, Q.C.

Prof. O.J. FIRESTONE

Dr. DAVID M. BALTZAN

COMMISSION COUNSEL:

Mr. R.N. HALL, Q.C.

COMMISSION SECRETARY:

Mr. N. LAFRANCE



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VOLUME 33

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Page No.

THE CANADIAN CHAMBER OF COMMERCE

6800

DR. F.W. JEFFREY, PAEDIATRIC  
CENTRE, OTTAWA

6871

CANADIAN FEDERATION OF AGRICULTURE

6902

CIVIL SERVICE FEDERATION OF CANADA

6971







1 Ottawa, Ontario,  
2 Monday, 19th  
3 March, 1962.

4 --- On commencing at 10 a.m.

5 THE CHAIRMAN: Ladies and gentlemen,  
6 we will come to order and proceed with our hearings  
7 scheduled for today. This is the ninth province that  
8 we have been in. This is really our second go here  
9 because we had a preliminary meeting in September. From  
10 the agenda that Mr. Lafrance has produced, it is obvious  
11 that there is great interest in the subject of health  
12 service in Ontario as well as in the rest of Canada.

13 Here we will be receiving briefs from  
14 national as well as local organizations and from the  
15 briefs that have been submitted we anticipate receiving  
16 a great deal of help and we are here to have submissions  
17 from those who have indicated their intention of being  
18 here and so that there may be no mistake about it, we  
19 are also prepared to hear from others who may not as yet  
20 have indicated their intention of appearing, and I would  
21 appreciate it if that fact could be made known by the  
22 news media.

23 Now, Mr. Hall, are you ready to proceed  
24 this morning?

25 MR. HALL: Mr. Chairman, members of the  
26 Commission, the first submission is that of the Canadian  
27 Chamber of Commerce. I would ask, Mr. Chairman, that the  
28 brief submitted by the Canadian Chamber of Commerce be  
29 filed as Exhibit 188.  
30







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TORONTO, ONTARIO

1 --- EXHIBIT NO. 188: Submission of the Canadian Chamber  
2 of Commerce.

3  
4 SUBMISSION OF THE CANADIAN CHAMBER  
5 OF COMMERCE.

6 Appearances: J.W. Bradshaw  
7 P.J. Girard  
8 W.J. Hall  
9 C.A.J. Quinn

10 MR. HALL: I will call upon Mr. J.W.  
11 Bradshaw, the Chairman of the Executive Council of the  
12 Canadian Chamber of Commerce to introduce the members  
13 of his delegation and give you the background of the Canadian  
14 Chamber of Commerce.

15 THE CHAIRMAN: Mr. Bradshaw please.

16 MR. BRADSHAW: Mr. Chairman, Madam  
17 Girard, and gentlemen, the Executive Council of the  
18 Canadian Chamber of Commerce is very grateful to have  
19 this opportunity of presenting its views to the Royal  
20 Commission on Health Services. Our brief, which you have  
21 received in advance, is based on the policies and prin-  
22 ciples of the Canadian Chamber, which have been adopted  
23 in a democratic procedure at its annual meeting held in  
24 Halifax last October.

25 This brief is now presented by the  
26 Chamber's Executive Council, which is the governing body  
27 of the Chamber. That  
28 is the governing body of the Chamber and the Executive  
29 Council is appointed to carry out the day-to-day  
30 of the Chamber in the interim between meetings of the  
31 Board of Directors.





1 Now, our chief spokesman for our delega-  
2 tion will be Mr. Fred Cunningham. Mr. Fred Cunningham  
3 is Chairman of the Chamber's Committee on Health Services  
4 and he is also past Chairman of the Executive Council.

5 Other members of the delegation are Mr.  
6 George Keeping, on my right, who is Vice-Chairman of the  
7 Executive Council. Mr. D.L. Morrell, sitting immediately  
8 on my right, who is the General Manager of the Chamber  
9 and Mr. W.J. McNally, sitting on my left, who is the  
10 Manager of the Policy Department. On my far left is Mr.  
11 Alec Turner, Research Assistant to the Chamber and I am  
12 F.W. Bradshaw, Chairman of the Executive Council.

13 In reiterating what was said by our  
14 representative at your preliminary hearing last September,  
15 the Executive Council wishes to make it quite clear at  
16 the outset that the Chamber believes that the attainment  
17 and preservation of national health is an objective of  
18 utmost importance to all Canadians. Realization of this  
19 objective would result in Canadians leading fuller, richer  
20 and more rewarding and productive lives with a minimum of  
21 hardship and suffering and by "richer" I mean richer in  
22 both the social and the monetary sense.

23 Now, the Council's submission suggests  
24 what we believe to be constructive ways for fulfilling  
25 this prime objective. Now sir, you have already received  
26 copies of our brief so I am assuming that you do not wish  
27 us to read the brief and I will call on Mr. Cunningham,  
28 if he will present a short statement covering its high-  
29 lights and then we will be prepared to answer any questions  
30 which you may have.







1 THE CHAIRMAN: I would not want Mr.  
2 Cunningham to feel that he need necessarily put it in in  
3 any short form. I think that you should develop, and we  
4 are very happy to have you develop, any arguments and  
5 points as you go along or as you may see fit.

6 MR. CUNNINGHAM: Mr. Chairman, and  
7 members of the Royal Commission, I have developed here  
8 a summary of the highlights of our brief which I would  
9 like to read into the record.

10 The Canadian Chamber of Commerce is a  
11 national voluntary federation of over 850 community  
12 Boards of Trade and Chambers of Commerce throughout  
13 Canada. About 75% of these individual Boards and Chambers  
14 serve communities of less than 5,000 population. Accord-  
15 dingly, the majority representation in the Canadian  
16 Chamber is small business.

17 We have endeavoured to present the Commis-  
18 sion with a brief of a helpful and constructive character.  
19 There are 26 individual recommendations summarized on  
20 pages 29 to 32.

21 The Chamber has a Policy Declaration on  
22 "National Health and Health Services" which is attached  
23 as Appendix A on page 23. It was adopted at the Annual  
24 Meeting last October and it states the convictions and  
25 beliefs of the membership from all parts of Canada.

26 Our present submission follows the  
27 general principles embodied in the Declaration and in the  
28 other Policy Declarations of the Chamber, all of which  
29 were also adopted last October. The basic principles  
30 have been embodied in the Chamber's Declarations for years.







1 and the Chamber has had a policy on National Health for  
2 ten years.

3               The Chamber believes that Canada should  
4 have as an objective the best possible health care for its  
5 people. The present standards of medical practice in  
6 Canada are among the highest in the world.

7               The rapid growth in the last decade of  
8 the percentage of the Canadian population covered by some  
9 kind of medical care prepayment or insurance plan is  
10 evidence of an increasing capacity to meet the expenses of  
11 sickness and accident. Consequently most Canadians now  
12 are in a position to secure excellent care and treatment  
13 for illness and accident. We recognize that there is  
14 always room for improvement and that there are areas in  
15 which the further expenditure of public funds is justified.

16              The Chamber believes that it is most  
17 important to inform and educate the people of Canada in  
18 health matters. Public and private health agencies  
19 should be encouraged to intensify their programs to promote  
20 good health. A widespread knowledge of health care and  
21 of the appropriate use of existing facilities would  
22 undoubtedly decrease the incidence of serious illness.  
23 Likewise, a continued and intensified program of accident  
24 prevention would be most desirable. We believe it quite  
25 possible to reduce the quantity of expensive medical care  
26 needed by the Canadian people.

27              There appears to be a grave danger of a  
28 shortage of doctors and dentists and other professional  
29 and technical personnel involved in health care. It is  
30 therefore desirable that suitable young people be attracted





1 to this field and encouraged to complete the necessary  
2 amount of education. Although the medical and dental  
3 faculties of some of our universities admit of no further  
4 expansion, others should be encouraged to enlarge and,  
5 under appropriate conditions, medical and dental faculties  
6 should be opened in universities not yet in this field.

7 The Chamber favours the expansion of  
8 medical research in Canada. It believes that research  
9 should be stimulated and encouraged in order that our  
10 present high standards of medical care should be maintained.

11 The Chamber regards very highly the  
12 present programs for training and rehabilitating handi-  
13 capped persons. The humane and economic consequences are  
14 of such significance that it believes this program should  
15 be given every encouragement both by Government and  
16 private industry.

17 The Chamber favours the continuation of  
18 the program of National Health Grants which might be made  
19 more effective by a re-appraisal of the amounts available  
20 by category, with a view to further facilitating the  
21 transfer of amounts from one category to another.

22 The Chamber is much impressed by the  
23 rapid growth of voluntary medical care prepayment and  
24 insurance plans. Bearing in mind that the Government  
25 hospital care program now covers practically all Canadians,  
26 it is significant that approximately half the population  
27 is now covered by some form of voluntary medical benefit  
28 plan, a five-fold increase in numbers in ten years. The  
29 majority of health care plans arranged through the medium  
30 of group insurance also cover wives and dependent







1 children, and the employer nearly always assumes a substan-  
2 tial share of the contribution. There has been an increa-  
3 sing tendency for this type of cover to be continued  
4 after the individual retires. Likewise, some plans have  
5 already been developed and others are in preparation to  
6 provide health care prepayment and insurance plans for  
7 individuals and groups not heretofore regarded as  
8 insurable. We believe that individuals and employers  
9 would find it worthwhile to secure health care cover now  
10 available at moderate cost from the many voluntary plans.

11                   The Chamber favours a well balanced  
12 program of social welfare related to the capacity of the  
13 Canadian economy and the public interest. It believes  
14 that the individual in our type of civilization is  
15 responsible for his own needs and that of his dependents.  
16 Unfortunately, there are those who cannot care for them-  
17 selves and Government aid is necessary for these people.

18                   The Chamber believes that the Nation  
19 should carefully assess any extension of our present  
20 program of welfare benefits. The existing commitments  
21 are most substantial and are recurring and increasing.  
22 The expenditure of public funds in one area of welfare  
23 leaves that much less available for other essential  
24 needs such as education. The Chamber is concerned about  
25 the future. The country appears to be faced with a  
26 dangerously increasing proportion of the national income  
27 required to meet Government expenditures of which welfare  
28 payments form an ever-increasing part.

29                   The Chamber is opposed to any form of  
30 compulsory national health insurance plan or socialized







1 medicine. There is no evidence that it is necessary and  
2 the Chamber firmly believes that adequate medical care  
3 can be provided for Canadians under our present system  
4 and paid for by the people through the medium of voluntary  
5 health care prepayment and insurance plans. Government  
6 assistance will be required only for those who are unable  
7 to pay the costs.

8                   The Chamber is convinced that a compul-  
9 sory national plan is not only unnecessary but would  
10 impose an unbearable additional strain on the finances  
11 of the country. The Canadian people already have demon-  
12 strated their ability to provide for their own health  
13 care costs, except for the indigents who require assistance.  
14 Moreover, such a plan would inevitably require more and  
15 more Government control and regulation, with consequent  
16 infringement of the freedom of the individual.

17                   MR. HALL: Mr. Cunningham, in your brief,  
18 on page 2, you deal generally with the question of  
19 Canadians and their health. Would you, for the benefit  
20 of the Commission, elaborate somewhat upon the points  
21 that you make in that section of your brief?

22                   MR. CUNNINGHAM: We have attempted in  
23 this section to deal in a general way with the whole  
24 picture of the health of our Canadian people. We believe  
25 that a continuous improvement in the standard of health  
26 services in Canada depends upon advances in the following  
27 fields:

28                   (1) Dissemination and utilization of  
29 health information and the promotion  
30 thereby of healthful living habits;





1 (2) Prevention of disease and accidents  
2 however caused;

3 (3) Early diagnosis and treatment of  
4 disease;

5 (4) Rehabilitation of the disabled and  
6 care for the chronically ill and  
7 incurable.

8 We believe there is no substitute for  
9 individual responsibility. We believe that the indivi-  
10 dual effort of an informed person acting through  
11 enlightened self-interest is of paramount importance to  
12 the preservation of his health and that of his family;  
13 for example, it is the individual who must consult his  
14 physician for early and preventive care, avoid obesity  
15 and alcoholism, exercise properly and drive his automobile  
16 safely.

17 No amount of well-intentioned legislation  
18 will be of any real assistance in such areas. These  
19 things cannot be done for him.

20  
21  
22 -

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B"  
Aw.

1 Then we have the recommendation arising from that  
2 particular section in the brief.

3 We recommend that: Further extension of  
4 financial assistance by the Federal Government to aid  
5 Canadians in meeting their medical expenses should be  
6 directed only to those areas in which the expense of  
7 the illness is clearly beyond the means of the in-  
8 dividual.

9 MR. HALL: Just by way of explanation of  
10 that recommendation, Mr. Cunningham, when you  
11 refer to "the expense of the illness is clearly  
12 beyond the means of the individual," you refer there  
13 to the entire expense or portion of the expense?  
14 I mean, do you recognize there are situations where an  
15 individual may be able to meet a portion of the expense  
16 but not all of it?

17 MR. CUNNINGHAM: You are referring to all  
18 the different degrees of indigency. There are those  
19 who cannot pay anything and there are those who couldn't  
20 pay the whole gross account, and there is an area in  
21 between where an individual can pay part but not all.  
22 We have had all those things very much in mind, and they  
23 are reflected in the subsequent recommendations we make.

24 MR. HALL: And you subsequently in your brief,  
25 for the benefit of the Commission, advise how you would  
26 determine an indigent, I believe.

27 MR. CUNNINGHAM: Well, later on in the brief  
28 there is a section dealing with indigents, and in that  
29 section we advocate a continuation of the present means  
30 test system of determining those who are in need.







1 MR. HALL: We will deal with that section  
2 a little later on, Mr. Cunningham.

3 Getting on with your brief, you devote a  
4 considerable portion of your brief to the general  
5 topic of promotion of good health, and you break that  
6 down into preventive medicine, the role of business  
7 and industry in health and accident prevention, and so  
8 on. Would you elaborate in general terms and go  
9 on to the particular sub-topics.

10 MR. CUNNINGHAM: We believe that the  
11 maintenance and continued improvement in the health  
12 standards of Canadians is a matter of prime importance.  
13 Much valuable work is presently being done in the  
14 promotion of good health and the prevention of  
15 accidents by many voluntary agencies including health  
16 leagues, accident prevention associations, and by  
17 industry. Credit is also due to federal, provincial  
18 and local governments which, through co-operative  
19 public health service programmes, have made an in-  
20 valuable contribution to the standards of health that  
21 Canadians now enjoy. We feel that these programmes  
22 could be made even more useful by added stress being  
23 placed on the dissemination of health information.

24 We deal then with the question of preventive  
25 medicine and as an illustration of the need for further  
26 education and information of the public on how to take  
27 care of their ordinary health needs. We have a figure  
28 of 60% quoted which arises from statistical observations  
29 by the Bell Telephone Company in Canada, which in turn  
30 is an accurate reflection of a very much larger group





1 of employed persons through the American Telegraph  
2 Company. They say that about 60% of Canadian people  
3 are found to meet completely satisfactory standards of  
4 health. Those are the people who apply to the  
5 telephone company for work in all categories, clerical,  
6 tradesmen, and so on. 60% are found to meet completely  
7 satisfactory standards of health, and we would deduce  
8 from that that there would seem to be a clear need  
9 for more health instruction in all levels of ed-  
10 ucational institutions and for more preventive health  
11 care measures. We point out that in the industrial  
12 setting approximately 3% of applicants come to industry  
13 with defects of a non-correctible character which will  
14 require continued health supervision of some degree  
15 throughout life.

16 Then in the next section under the "Role  
17 of Business and Industry in Health," dealing with  
18 health insurance plans, these are the plans generally  
19 arranged by an employer or a group of employers to  
20 provide some health care for his employees. We say  
21 that business has played an important role in the past  
22 improvements in the health of Canadians by virtue of  
23 its promotion of health insurance plans among its  
24 employees. In a Department of Labour Survey covering  
25 6,166 manufacturing establishments employing over  
26 1,000,000 persons, it was indicated that of this group,  
27 97% were then working in establishments which reported  
28 the existence of a health insurance plan, and in Table  
29 1 on page 4 of our brief some details of these  
30 statistics from the Department of Labour are set forth.







1 In addition to the foregoing, many business  
2 associations and other groups across Canada are now  
3 availing themselves of a wide variety of private  
4 medical care insurance plans on a group basis. For  
5 example, a number of community Boards of Trade and  
6 Chambers of Commerce in Canada have voluntarily  
7 organized plans for their members and their members'  
8 employees. These are plans to assist them in meeting  
9 the cost of health care.

10 Under the sub-section dealing with medical  
11 facilities, we are largely quoting from information we  
12 secured from the Canadian Medical Association; I  
13 imagine they will probably repeat some of that in their  
14 own brief.

15 Sickness and accident leave benefit plans.  
16 In Canadian industry, a large majority of both plant  
17 and office employees are employed by companies where  
18 a sickness and accident leave benefit plan is in  
19 operation as is illustrated by Table 2 on page 7.  
20 Incidentally, it says "Plant in Operations." It  
21 should be, "Plan in Operation."

22 Under Workmen's Compensation we show in  
23 our appendix a rather interesting table showing the  
24 benefits that are provided by the Workmen's Compensa-  
25 tion legislation in the various provinces. These  
26 benefits are provided both in the event of death of  
27 the workman and in the event of his accidental dis-  
28 ablement at work. That will be in Appendix D on page  
29 36.

30 On page 9, in the section on Accident





1 Prevention, we rely here to a great extent on statistics  
2 provided by the various publications of the Dominion  
3 Bureau of Statistics and of the National Safety Council,  
4 a United States organization.

5 According to statistics published recently  
6 by The National Safety Council, there has been a re-  
7 duction in the all-industry injury rate in North  
8 America of 57% in 13 years. Canadian experience is  
9 reflected in these statistics. Workmen's Compensation  
10 legislation requires minimum precautions but many en-  
11 lightened companies are attempting to reduce wasteful  
12 disabling accidents to zero.

13 Arising from this whole second section of  
14 our brief on prevention, we derive two recommendations.  
15 The first is that those employers who have not already  
16 done so should consider the introduction of health  
17 services or where this is not feasible and the need  
18 for such services is clear, they should consider the  
19 possibility of co-operating with other employers in the  
20 same area in a pooling arrangement which would enable  
21 the participants to avail themselves of improved health  
22 services for their employees.

23 And second, Governments Federal, Provincial  
24 and Municipal take the lead in developing a co-ordinated  
25 public education programme covering the individual's  
26 role in maintaining high standards of good health and  
27 fitness and in practising safety consciousness.

28 MR. HALL: I believe, Mr. Cunningham, that  
29 you have also given some thought to the question of  
30 medical manpower and medical research as it relates to







1 the treatment and care of the sick. Will you explain  
2 to the members of the Commission your views on this point?

3 MR. CUNNINGHAM: This is in the next large  
4 section. This section is entitled "Treatment and  
5 Care of the Sick." Under "Medical Manpower" we say  
6 that the Executive Council is concerned about the  
7 possibility that Canada's medical manpower resources  
8 may not be adequate to treat the anticipated rapid  
9 population increase of the future. To quote ex-  
10 tensively from a recent study, we quote:

11 "A rough measure of adequacy of medical  
12 services is the physician-population ratio. During  
13 the period 1900-1950 the national ratio in Canada has  
14 been, with remarkable constancy, of the order of 1:980,  
15 that is one physician to 980 population. We estimate  
16 that the current ratio is 1:888, a more favourable  
17 figure than we have ever enjoyed, and one which compares  
18 favourably with that of the more advanced countries  
19 of the Western world. It will be appreciated that  
20 ratios of the type mentioned here represent gross  
21 figures of medically qualified persons and that not all  
22 of the doctors are engaged in the care of patients.

23 Then we go on to cite various figures  
24 derived from sources which are identified in the foot-  
25 notes at the bottom of page 10 and at the bottom of page  
26 11, which indicate the risk that we run in the future  
27 of developing a situation where there is likely to be a  
28 very serious shortage of doctors, of dentists, probably  
29 of nurses, and of various other personnel attached to  
30 the medical treatment of the people.





1           Then we say that the attraction of an increased  
2 number of suitably qualified people into the Canadian  
3 medical manpower force has to be pursued if we are to  
4 continue to enjoy our improving standards of health.  
5 There is nothing to suggest that the introduction of  
6 "socialized medicine" in Canada would improve the supply  
7 of physicians.     Incidentally, the definition of  
8 "socialized medicine" is later on at the foot of page  
9 25; we thought it wise to include a definition of what we  
10 meant when we were talking about "socialized medicine."  
11 That is in the footnote.     On the contrary, there is good  
12 evidence that fewer suitable students would be attracted  
13 into medicine.     In England, after more than a decade of  
14 "socialized medicine", an acute shortage of physicians  
15 is developing.     Doctor-patient ratios are deteriorating  
16 and the intake of medical students has declined from  
17 2,741 in 1955-56 to 2,504 in 1958-59.     The number of  
18 full-time medical students in England is now only 4%  
19 larger than before the Second World War compared to a  
20 population increase of nearly 10%.     "Furthermore,  
21 there are signs of failure in the supply of principals in  
22 general practice and of consultants in anaesthetics,  
23 radiology, pshchiatry and E.N.T.     (Ear, Nose and Throat)  
24 Surgery."

25

26

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29

30







1 One reason for the shortages is the  
2 fact that each year since 1955, 220 British doctors  
3 have been settling in Canada alone.

4 Under the Health Grants Program, which  
5 is tabulated, the amounts granted for the past 12 years  
6 are tabulated in the Table on Page 12. This table shows  
7 that under Canada's National Health Grants Program, over  
8 530 million dollars was made available from the inaugura-  
9 tion of the program in 1948 over the 12-year period until  
10 1960. Actual expenditure during the period was a little  
11 less than 400 million, or 74% of the amount made available,  
12 and approximately a third of the total was spent on hospi-  
13 tal construction.

14 Under the submission on Medical Research,  
15 we say:

16 "Medical science research in Canada is  
17 supported by the federal and provincial  
18 governments, by private foundations, by  
19 business and industry, by voluntary  
20 agencies and by universities and hospi-  
21 tals. Without adequate research there  
22 can be little progress in medical sciences.  
23 We consider the partnership of private  
24 and public agencies and funds to be  
25 sound for progress in the medical research  
26 field. We would welcome any reasonable  
27 extension of medical research, but in  
28 such a technical field, we do not consider  
29 ourselves competent to make firm recommen-  
30 dations.





1 One area which deserves more considera-  
2 tion is administrative research, that is,  
3 research into the most efficient method  
4 of utilizing available medical resources;  
5 this is of particular importance in the  
6 field of hospital administration where a  
7 reduction of one day in the average  
8 hospital stay, for example, would free  
9 thousands of costly hospital beds.

10 It is thus desirable whenever practical  
11 to transfer patients from intensive care  
12 beds to less intensive care beds or to  
13 convalescence centres. Due to the lower  
14 cost of such less intensive care beds  
15 and convalescence centres, considerable  
16 economies can thus be effected. In this  
17 same field, the benefits to be obtained  
18 from the availability of home care facili-  
19 ties including visiting-nurse services,  
20 should not be overlooked."

21 Our recommendations with respect to  
22 Medical Manpower are three in number:

23 "First; in order to educate and develop  
24 the medical manpower required in future,  
25 encouragement should be given to univer-  
26 sities and technical schools to enlarge  
27 their facilities and, where appropriate,  
28 the establishment of new educational  
29 institutions should also be encouraged.  
30 Second; more and larger scholarships,







1 loans and bursaries be made available in  
2 all categories of medical education,  
3 including dentistry, for those students  
4 who prove their suitability.

5 Third; moderate additional relief should  
6 be extended to lighten the Income Tax  
7 burden as proposed in the following  
8 extract from a statement of Chamber  
9 policy:

10 'The Canadian Chamber of Commerce urges,  
11 therefore that ... to provide financial  
12 encouragement for parents to permit  
13 children to attend schools or universities,  
14 Section 26(1)(c)(iii) of the Income Tax  
15 Act be amended to provide \$1,000.00 rather  
16 than \$500.00 exemption for children not  
17 qualified for family allowance in full-  
18 time attendance at a school or university."

19 With respect to the Health Grants, we

20 recommend that:

21 "The program of National Health Grants  
22 should be continued with reappraisals of  
23 the amounts available by category with a  
24 view to further facilitating the transfer  
25 of amounts from one category to another."

26 In connection with Medical Research, we

27 recommend first:

28 "Medical research by universities and  
29 other qualified organizations and  
30 groups be further stimulated with





1 additional resources being made available  
2 to them", and second:

3 "Studies should be made with a view to  
4 reducing the average length of hospital  
5 stays and their average cost per day".

6 And we make a general recommendation:

7 "Special study should be made of those  
8 geographical areas in which medical  
9 services are inadequate, and Federal  
10 and Provincial governments should encour-  
11 age the possibility of stimulating the  
12 development of needed facilities with  
13 emphasis on the use of local resources  
14 and local talents".

15 MR. HALL: Mr. Cunningham, could you,  
16 for the benefit of the Commission, expand upon your  
17 thoughts on rehabilitation, and the recommendations you  
18 make in that regard?

19 MR. CUNNINGHAM: This is covered in the  
20 fourth section of our brief, where we deal with the  
21 question of rehabilitation. We say:

22 "Rehabilitation is defined in its  
23 broadest sense as 'a system of comprehen-  
24 sive related services dedicated to the  
25 total welfare of the disabled'. Canada's  
26 national program of rehabilitation was  
27 initiated in 1951 (Rehabilitation Services  
28 in Canada, Part 1. Research and Statistics  
29 Division, Department of National Health  
30 and Welfare, Ottawa, March, 1960) at a







1 national conference of all the organiza-  
2 tions and groups in the country that  
3 were working directly for the handicapped  
4 or were concerned with their welfare.

5 There were at that time 423,000 Canadians  
6 severely or totally disabled (256,000 of  
7 them of working age). (Source: Rehabili-  
8 tation for the Disabled in Canada - A  
9 Plan for National Action, Edward Dunlop,  
10 O.B.E., G.M., September, 1958.) Since  
11 that time, every province has developed  
12 a means of co-ordinating rehabilitation  
13 activities and most provinces have  
14 appointed 'Co-ordinators of Rehabilita-  
15 tion' to bring about close co-operation  
16 between the organizations whose services  
17 contribute to rehabilitation. Services  
18 for the rehabilitated have been expanded  
19 in all provinces."

20 Arising from that, and various other  
21 things we have said about rehabilitation, we have a number  
22 of recommendations.

23 "First; employers continue to co-operate  
24 in the placing of handicapped persons  
25 in suitable jobs.

26 Second; employers who have not already  
27 done so, investigate the possibility of  
28 employing handicapped persons.

29 Third; the Federal Government should  
30 further encourage and support the provinces





1 in every way possible to develop co-ordi-  
2 nated rehabilitation programs which will  
3 provide such facilities and services as  
4 are necessary to bring comprehensive  
5 rehabilitation to those individuals who  
6 can benefit.

7 Fourth; in developing such services,  
8 the fullest co-operation of employers,  
9 employees, government and voluntary  
10 agencies be encouraged", and fifth;  
11 "We reiterate the policy of the Canadian  
12 Chamber of Commerce with respect to  
13 following recommendation: Consideration  
14 be given to allowing as deductions under  
15 the Income Tax Act the expenses incurred  
16 relating to the care and training of  
17 handicapped dependants."

18 MR. HALL: In your introductory summary,  
19 you devoted a large portion of it to dealing with volun-  
20 tary medical care plans. Can you go into more detail on  
21 that topic?

22 MR. CUNNINGHAM: "Voluntary medical care  
23 plans have been in existence for many  
24 years, but their large-scale development  
25 began only twenty years ago. There are  
26 numerous private organizations providing  
27 insurance against the costs of sickness.  
28 Over eighty insurance companies offer a  
29 wide variety of contracts in this field.  
30 Blue Cross plans still operate in four







1 provinces despite the advent of the  
2 provincial hospitalization programs.  
3 Medical and surgical expense insurance  
4 is issued under medical care plans spon-  
5 sored by the medical profession. In  
6 addition, medical care benefits are made  
7 available through numerous insurance  
8 co-operatives, fraternal benefit societies,  
9 employee benefit associations and through  
10 union-sponsored plans".

11 We give an example of the cost of some  
12 of these things. These are insurance plans. One, which  
13 we would call rather a minimum type benefit, would cost  
14 18¢ a day. That would be an individual purchase by a  
15 man for himself, his wife, and two children, and then a  
16 little more liberal type of benefit would cost approxi-  
17 mately twice that amount.

18 We point out that "the most recent addi-  
19 tion to the types of medical care plans  
20 available is the 'comprehensive or  
21 major medical benefits' type of insurance  
22 plan. This type of plan has only been  
23 widely available since 1956. Such plans  
24 are sometimes called 'catastrophic'  
25 benefit plans and benefits are payable  
26 up to predetermined ceilings, generally  
27 in the range of up to \$5,000, with  
28 higher limits for group plans, should  
29 the insured incur catastrophic expendi-  
30 tures as a result of serious illness or





1 accident. This type of benefit coverage  
2 has increased very rapidly. In 1956,  
3 only 234,000 persons were so insured; in  
4 1960, this number had increased to  
5 2,035,000. The number of persons insured  
6 in this category increased from 1,179,000  
7 to 2,035,000 between the end of 1959 and  
8 the end of 1960."

9 We were rather interested in "a nine-city  
10 survey published by the Dominion Bureau  
11 of Statistics (City Family Expenditure,  
12 1957, Dominion Bureau of Statistics,  
13 Catalogue No. 620517) shows family  
14 expenditure patterns as of 1957."

15 This, I understand, is the latest such survey published  
16 by the D.B.S.

17 "In a nine-city composite table medical  
18 care expenditure amounted to 4.6% of  
19 total expenditure. This compares with  
20 9.4% expended on automobiles, 3.8% for  
21 smoking and alcoholic drinks and 2.9% for  
22 recreation. This indicates that there is  
23 room for some upgrading of the position  
24 which medical care occupies in the  
25 average family budget, although there  
26 are indications that this is taking  
27 place as we have already noted."

28 We have made two recommendations in  
29 connection with this matter; first, that

30 "Canadians place a higher priority on







1 budgeting for health care and in parti-  
2 cular avail themselves of the appropriate  
3 private insurance plan to assist in  
4 defraying the costs of medical care";  
5 and second

6 "Those employers who have not already  
7 done so consider the possibility of the  
8 installation of a medical and surgical  
9 care prepayment or insurance plan."

10 MR. HALL: The recommendation that  
11 Canadians place a higher priority on budgeting for health  
12 care and, in particular, avail themselves of the appro-  
13 priate private insurance plan as a matter of private  
14 decision; have you any recommendations as to how this  
15 recommendation be brought about as to education, have  
16 you any suggestions?

17 MR. CUNNINGHAM: In the first place, I  
18 would suggest that recommendations emanating from this  
19 Commission would have very great influence on the molding  
20 of public opinion in that respect; and secondly, this  
21 submission of ours, in printed form, will go to the  
22 membership of the Canadian Chamber and will reach  
23 employers, large and small, in all parts of Canada, and  
24 that too would be bound to develop some opinion.

25 MR. HALL: Arising out of that topic,  
26 is the question of indigents. May we have your thoughts  
27 and recommendations in that regard?

28 MR. CUNNINGHAM: The question of dealing  
29 with indigents was something which we spent a great deal  
30 of time in considering, and we regard it as one of the





1 most difficult problems faced by the people of Canada and  
2 by this Royal Commission in particular.

3 We point out in the Section of our brief,  
4 which commences on page 20, that there is a very general  
5 arrangement throughout the various provinces and terri-  
6 tories of Canada for the care of the indigent. Most of  
7 these indigents are the individuals who are already on  
8 public assistance rolls. There will be others too, who  
9 are normally self-supporting, but who, when faced with  
10 the requirement of medical care, may have to give up  
11 working, and would find themselves in the position of  
12 being unable to pay the whole, or part, of their medical  
13 bills.

14 We have quoted in this Section of our  
15 brief, starting on page 21, an outline of the manner in  
16 which each province and the two territories deal with the  
17 question of indigent persons.

18 We say "there is a variety of public  
19 welfare and social security benefits  
20 already available to indigent Canadians.  
21 In the field of federal-provincial pro-  
22 grams, Old Age Assistance, Allowances  
23 for Blind Persons and Allowances for  
24 Disabled Persons, benefits are made  
25 available on an eligibility-test basis.  
26 In the field of provincial programs,  
27 Mothers' Allowances and General Assis-  
28 tance is also similarly made available  
29 subject to conditions of eligibility  
30 which vary from province to province.







1 Health care for Public Assistance benefi-  
2 ciaries in every province and territory  
3 of Canada is regarded as a shared provin-  
4 cial-municipal responsibility as will be  
5 borne out" by the quotations which we  
6 have embodied in our brief, as I have  
7 said before, for each province and for  
8 the two territories.

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1 I would point out that while bad health is  
2 a contributing factor that affects these multi-problem  
3 families and may be the cause of aggravating other  
4 problems, it would seem that intensive research needs  
5 to be done on these families in order to rehabilitate  
6 them to independence. In St. Paul Minnesota, for  
7 example, surveys indicated that 6% of the country's  
8 families were using more than half of its total health  
9 and welfare resources, about twelve million dollars for  
10 approximately 6,000 families annually. Picking the  
11 140 families from the bottom of the social heap six  
12 full-time and two part-time social workers were assigned  
13 to them exclusively over the following three years.  
14 By seeking out the reasons for dependence and by working  
15 to overcome these conditions permanently, the St. Paul  
16 experiment resulted in 65% of the families changing for  
17 the better, 19% were unchanged and 16% had changed for  
18 the worst.

19 London, Ontario has mapped out a three-year  
20 pilot project for intensive treatment of 50 of its  
21 most troubled families after discovering that 250  
22 chronically distressed households for years had been  
23 going through about half a million dollars a year in  
24 social aid without an iota of permanent progress to show  
25 for it.

26 Arising from what we say we make five  
27 recommendations:

28 Firstly, the provision of health care for  
29 indigents be given careful study by the research staff  
30 of this Commission in order to ascertain the complete







1 facts of the situation relating to coverage and adequacy  
2 of treatment.

3 2. Any future extension or improvement in  
4 the medical care of indigents be made available to them  
5 on an eligibility test basis administered at the local  
6 level.

7 3. That the promotion of rehabilitation  
8 services through federal provincial cooperation, using  
9 the family centred approach for multi-problem families  
10 with a view to returning these families to an independent  
11 and productive place in society. To assist in mitigating  
12 catastrophic illness expenditures by normally self-  
13 supporting persons we recommend the following amendment  
14 to the Income Tax Act:

15 4. The 3% floor apply to incomes after the  
16 personal exemptions provided under section 26.

17 5. All medical expenses not deductible  
18 in any one year, due to insufficient income, be de-  
19 ductible from income on the same basis as business losses.

20 MR. HALL: I believe you have a recommendation  
21 to make in regard to the welfare benefits in general.

22 MR. CUNNINGHAM: Yes, sir. In an address  
23 made by Prime Minister Diefenbaker in May he said the  
24 following:

25 "In 1924... the annual expenditures on  
26 public welfare services including most forms  
27 of institutional care amounted in all of Canada  
28 to some 85 million dollars annually. 25 years  
29 later it amounted to 850 million dollars. 10  
30 years later in the year 1958-59, the sum of





1 2 billion, 850 million dollars was spent on  
2 health and welfare by all levels of government."

3 He went on to say "Over the twenty years from  
4 the fiscal year 1939 to the fiscal year 1959 all levels  
5 of government in Canada increased expenditure on health  
6 and welfare from 7.7% of the net national income to  
7 11.2%. In Great Britain the percentage of net national  
8 income so expended in the same period was 12.1%; in  
9 the U.S.A. 7.7%."

10 We make some recommendations and one main  
11 recommendation is that the existing social welfare  
12 program in Canada being reasonably well balanced, various  
13 levels of government should consider carefully any  
14 additional commitments in this field and should bear in  
15 mind the substantial demands on public funds to meet  
16 other essential needs.

17 MR. HALL: You express some concern for  
18 the future and make some recommendations in that regard;  
19 will you elaborate on those?

20 MR. CUNNINGHAM: Yes. We say, amongst  
21 other things, that we are concerned about the appeal  
22 that a tax supported comprehensive health plan can have  
23 and its potential vote catching nature. We are also  
24 concerned about the possibility of a variety of plans  
25 being advocated, each endeavouring to outdo the other  
26 to capture public favour with little concern for the  
27 irreparable effects such plans could have on our future  
28 economic growth, upon which ultimately all welfare  
29 benefits depend. We concur with the view that  
30 "social benefit schemes are an important instrument in







1 the hands of the collectivists who would achieve their  
2 ends by the process of redistribution of income.  
3 They appeal to the emotions, to the normal human desire  
4 to leave want and suffering, taking advantage of the  
5 uninformed and creating the illusion that omnipotent  
6 government can create Utopia here and now."

7 We go on at length in this section to point  
8 out, as I intimated in summarizing the highlights of our  
9 brief, that our concern is in the increasing proportion  
10 of the national income that is required now to meet  
11 health and welfare demands. We end up by making these  
12 recommendations, all with very great respect to you,  
13 Mr. Chairman and members of the Commission:

14 1. Any recommendations of this Commission  
15 to the Federal Government should be aimed at preserving  
16 the freedom of the individual.

17 2. Any recommendations of this Commission  
18 be aimed at opposing the introduction of a "socialized  
19 medicine" scheme in Canada.

20 3. No further general expansion of social  
21 welfare programs be undertaken until the full impact of  
22 the present programs becomes apparent.

23 MR. HALL: Mr. Chairman, Mr. Cunningham  
24 and the members of his delegation are prepared to answer  
25 any questions which the Commission may have.

26 THE CHAIRMAN: Thank you very much, Mr.  
27 Cunningham. We are very grateful to you and your  
28 associates for the time and thought and research that  
29 has gone into the preparation of this document.  
30 Naturally the views that we may take as to the re-





1 commendations you have made, it is too premature to express  
2 any opinion, you will appreciate, but the quality of your  
3 brief is something that we are now entitled to comment  
4 upon in putting forward your views as clearly and  
5 documented as they have been.

6 Now, we will have certain questions because  
7 naturally we wish to explore the situation perhaps a little  
8 more fully. You may recognize that in having the  
9 Canadian Chamber of Commerce before us we are dealing with  
10 those people who are entitled to speak for the business  
11 interests both large and small of the nation.

12 COMMISSIONER FIRESTONE: Mr. Chairman:  
13 Mr. Cunningham, I am addressing some questions to you  
14 but please feel free to call on any of your associates  
15 to deal with the questions if you want to do so. My  
16 first question refers to the statement made on page 19  
17 where you say, you recommend that Canadians place a  
18 higher priority on budgeting for health care. What  
19 are your reasons for placing such a higher priority on  
20 budgeting for health care. I presume this means  
21 spending more money on health care?

22 MR. CUNNINGHAM: What we had in mind was  
23 that, as we have said in more than one place in our brief,  
24 we believe the Canadian people are well able to pay their  
25 own bills for the various forms of medical service that  
26 is required. There are many cases where the individual  
27 and the individual families have difficulty in meeting  
28 these unusual costs that usually arise suddenly and  
29 unexpectedly and from the surveys that have been made  
30 some of them by D.B.S., the consumers price index







1 indicates a factor of 4.4% for medical care expenses;  
2 that does not include hospitalization which is now taken  
3 care of pretty well.

4 We feel that in the light of the much larger  
5 proportions that the every day Canadian family is spending  
6 on things that we believe should take second position  
7 to matters of health -- well, tobacco and alcohol were  
8 two that we quoted in there and the money spent on auto-  
9 mobiles and luxuries -- that is far more substantial than  
10 that which has been set aside to provide for the ex-  
11 igencies of medical situation that develop in the normal  
12 family.

13 We believe that if they could be persuaded  
14 through a process of information and education and keep  
15 pounding away at it that these things have to be taken  
16 care of and are likely to occur some day that it would  
17 have some effect, perhaps.

18 COMMISSIONER FIRESTONE: What are your  
19 reasons for attaching this higher priority?

20 MR. CUNNINGHAM: So there will be fewer  
21 cases turing up in the long run where somebody else has  
22 to turn in and pay their bills for them.

23 COMMISSIONER FIRESTONE: Have you in mind  
24 perhaps that you feel that improved health services made  
25 available to the Canadian public will contribute an im-  
26 provement in the health of the Canadian nation? Is  
27 that one of the reasons you are recommending a higher  
28 priority on budgeting for health care?

29 MR. CUNNINGHAM: Yes, I would say that.

30 COMMISSIONER FIRESTONE: And you would go





1 on and say if Canadians enjoy better health this may  
2 affect the productivity of the nation, and as business  
3 people you are interested in productivity?

4 MR. CUNNINGHAM: Very definitely. We  
5 quote in our brief from the Bell Telephone experience,  
6 I forget the figure on loss of time through illness.

7 COMMISSIONER FIRESTONE: Therefore, your  
8 point is that you are in favour of the Canadian nation  
9 spending more money on health because it is likely to  
10 mean a healthier nation and a healthier nation would  
11 mean a higher productivity and higher output?

12 MR. CUNNINGHAM: When we say "health", it  
13 is preventive health.

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1 COMMISSIONER FIRESTONE: Just to under-  
2 stand the point, when you speak of higher priority on  
3 budgeting for health care, do you cover under health  
4 care all health services or just preventive health?

5 MR. CUNNINGHAM: That would be all health  
6 services.

7 COMMISSIONER FIRESTONE: Then the answer  
8 is all health services?

9 MR. CUNNINGHAM: That is right.

10 THE CHAIRMAN: You had a comment?

11 MR. McNALLY: I was just going to say  
12 we believe very strongly in the fundamental spirit of  
13 independence and self-respect of the average Canadian  
14 and through education and through information we believe  
15 that they can be induced perhaps to spend less on alcohol  
16 and tobacco, and that type of thing, and budget a little  
17 bit more for their own health service so that they can  
18 stand on their own feet.

19 COMMISSIONER FIRESTONE: This is a helpful  
20 observation sir. We are concerned here with the thinking  
21 of the Chamber of Commerce and I take it from what you  
22 gentlemen have been saying that you are in favour of the  
23 nation as a whole spending more money for health services?

24 THE CHAIRMAN: If this is a paraphrasing  
25 of the recommendations, it is not the way I read it. You  
26 are talking about the individual spending more?

27 MR. McNALLY: Yes, that is right.

28 COMMISSIONER FIRESTONE: I would like to  
29 have an understanding of what you mean. You mean that  
30 the individual should be spending more or would you not





1 say that if individual Canadians spent more, the nation  
2 as a whole will be spending more?

3 THE CHAIRMAN: I mean two and two still  
4 make four.

5 COMMISSIONER FIRESTONE: Mr. Chairman,  
6 if I can have some reply from him.

7 THE CHAIRMAN: I would like the questioning  
8 and discussion to proceed on a basis which would be infor-  
9 mative to us in a matter beyond simple arithmetic.

10 COMMISSIONER FIRESTONE: If I am allowed  
11 to develop the question, the point will become apparent.  
12 Could you then say that if you are in favour of the  
13 nation, comprising a lot of individuals, spending more on  
14 health care - is that what you have in mind when you say  
15 "A high priority on budgeting for health care"?

16 MR. CUNNINGHAM: What we have in mind is  
17 that if more money is spent by the individual on preven-  
18 tive measures and in doing the things he should do to  
19 maintain a good standard of health he will, in the long  
20 run, have less expense that he will have to incur in  
21 curing himself of a sickness that he should not have  
22 developed in the first place.

23 COMMISSIONER FIRESTONE: This is a parti-  
24 cular point I am making: that it would be useful to spend  
25 more money on preventive medicine - I think that point is  
26 well taken. I was just referring to the paragraph (i)  
27 of your recommendations on page 19 and, as I understand,  
28 what you are driving at here "Canadians place a higher  
29 priority on budgeting for health care" - I understand  
30 you to say all health services. Is that correct, sir?







1 MR. CUNNINGHAM: Yes.

2 COMMISSIONER FIRESTONE: In paragraph (i),  
3 page 19?

4 MR. CUNNINGHAM: Yes.

5 COMMISSIONER FIRESTONE: Thank you sir.  
6 Now you continue on in this paragraph, and I take it, if  
7 the intent is to spend more money on health services,  
8 that money will come from individuals spending more on  
9 health services and in cases where individuals cannot  
10 spend more money on health services, the category which  
11 you have described as indigents, that additional money  
12 will come from the State. Is that your thinking?

13 MR. CUNNINGHAM: That is right.

14 MR. McNALLY: That is the only place  
15 from which it can come.

16 COMMISSIONER FIRESTONE: I would just  
17 like your views put on the record so the Commission can  
18 understand clearly. As the Chairman said we want to have  
19 the understanding of what some of these statements mean  
20 that you have made.

21 MR. CUNNINGHAM: When we say the State,  
22 we are talking about all levels of government normally  
23 contributing to the welfare of the indigents.

24 COMMISSIONER FIRESTONE: Therefore  
25 paragraph (i) on page 19 is that you would expect, and  
26 you would recommend in favour that Canadians individually  
27 spend more on health and that where they cannot afford  
28 to spend it, by reasons which you have enumerated in  
29 another section under the heading "Indigents", that these  
30 additional expenditures be made by the State, covering





1 all three levels of government. Is that your view, sir?

2 MR. CUNNINGHAM: We have that in mind,  
3 that these governments spend additional money that would  
4 be involved, yes.

5 COMMISSIONER FIRESTONE: Therefore, we  
6 are talking of a national health budget for Canadians  
7 which will involve more expenditures and more money  
8 coming partly from individuals and partly from government.  
9 This is my understanding of what you are saying and if  
10 this is so, do I understand that you subscribe to the  
11 principle of prepayment?

12 MR. CUNNINGHAM: That is right, or  
13 insurance which amounts to much the same thing.

14 COMMISSIONER FIRESTONE: You are in  
15 favour of prepayment. You are in favour of prepayment of  
16 all health care services or only certain health care  
17 services?

18 MR. CUNNINGHAM: All.

19 COMMISSIONER FIRESTONE: You are in  
20 favour of prepayment of all health care services. Does  
21 that include medical care services?

22 MR. CUNNINGHAM: Definitely, yes.

23 COMMISSIONER FIRESTONE: Does that  
24 include dental care services?

25 MR. CUNNINGHAM: I think so.

26 COMMISSIONER FIRESTONE: Does that  
27 include prepaid drug plan, or we are talking now about  
28 prescribed drugs, drugs prescribed by physicians?

29 MR. CUNNINGHAM: Yes.

30 COMMISSIONER FIRESTONE: The answer is







1 yes. Thank you. May I now turn to ---

2 MR. KEEPING: May I just interject, Mr.  
3 Chairman? We would be in favour of prepayment on a  
4 voluntary basis.

5 COMMISSIONER FIRESTONE: Thank you for  
6 the comment sir. I have occasion to come back to it, if  
7 I may. Now, if I may turn to page 17, you say, sir, in  
8 the first sentence, second paragraph, and I quote:

9 "Voluntary medical care plans have been  
10 in existence for many years, but their  
11 large-scale development began only 20  
12 years ago".

13 MR. McNALLY: Right.

14 COMMISSIONER FIRESTONE: Now sir, I am  
15 sure you are familiar with the results of a survey that  
16 was undertaken entitled "Voluntary and Medical Insurance  
17 in Canada" which showed that in 1958 - the survey is  
18 somewhat out of date - but in 1958 only 43% of the popula-  
19 tion of Canada was covered by voluntary prepayment plans.  
20 Are you familiar with the survey?

21 MR. McNALLY: This is the National Health  
22 and Welfare, yes.

23 MR. CUNNINGHAM: We have, in Appendix F  
24 on page 41, the up-to-date figures.

25 COMMISSIONER FIRESTONE: What proportion  
26 would you say is up to date?

27 MR. McNALLY: On page 41 sir.

28 MR. CUNNINGHAM: Appendix F, the upgraded  
29 figure from the 1958 survey.

30 COMMISSIONER FIRESTONE: And you suggest





1 now 1960 has 48%. Is that correct?

2 MR. McNALLY: Surgical is 51%.

3 COMMISSIONER FIRESTONE: We are talking  
4 about medical benefits.

5 MR. McNALLY: I am sorry, 48%.

6 COMMISSIONER FIRESTONE: All right, let's  
7 say there are 48% of the Canadian population covered by  
8 medical benefits. Now, you also mentioned that there  
9 were only about two million people covered by what one  
10 may describe as comprehensive coverage. Is that correct?

11 MR. CUNNINGHAM: This is something new.  
12 That is relatively new.

13 MR. McNALLY: That is on the same table,  
14 sir.

15 COMMISSIONER FIRESTONE: I appreciate  
16 that. I am just trying to draw a conclusion from these  
17 two sets of figures here. We have 48% having some form  
18 of coverage, 11% having a form of comprehensive coverage.  
19 Two million, incidentally, is about 11% of all the  
20 Canadian population so we have about 11% of that popula-  
21 tion having a comprehensive coverage including what is  
22 called major medical benefits or extended health benefits.  
23 Is that correct?

24 MR. CUNNINGHAM: That is right.

25 COMMISSIONER FIRESTONE: Now what happens  
26 to the remainder of the 48% which are not in this comprehen-  
27 sive coverage? Does it mean, in your opinion, that they  
28 are only covered partially?

29 MR. CUNNINGHAM: Well, part of the  
30 remainder would include the indigents for whom the







1 provinces are paying substantially, and then the balance  
2 would be paid out of the pocket of the individual.

2  
3 THE CHAIRMAN: I think you misunderstood  
4 the question. We are only talking of the 48% that were  
5 covered.

6 COMMISSIONER FIRESTONE: Yes, if you  
7 look, sir, at your table on page 41, you will find that  
8 48% includes plans of insurance companies, medical care  
9 plans, Blue Cross plans, medical society plans, independent  
10 plans. I do not see in this coverage anywhere a coverage  
11 provided for indigents.

12 MR. CUNNINGHAM: It is not covered, no.  
13 It is not.

14 THE CHAIRMAN: You were dealing with the  
15 people who were not covered at all in your answer.

16 MR. CUNNINGHAM: Oh, I see. Their  
17 expenses are paid by insurance and the balance would be  
18 paid by themselves.

19 COMMISSIONER FIRESTONE: Exactly sir.  
20 In other words, you have brought to the attention of the  
21 Commission, and I must say we are very grateful to you,  
22 because you are the first organization that has done so,  
23 and this is the ninth province in which we have appeared:  
24 you have brought to our attention a very basic fact that  
25 here are 48% of our people covered by some form of medical  
26 insurance. Of these, only 11% of the total population  
27 are covered by what can be described as comprehensive  
28 coverage. In other words, we still have a long way to go  
29 to provide comprehensive coverage for those between the  
30 11% and the 48%, plus providing coverage between those





1 that do not have any coverage at all. Is that correct?

2 MR. CUNNINGHAM: Yes.

3 COMMISSIONER FIRESTONE: This is very  
4 helpful to us sir in establishing these basic facts which  
5 have not been brought before this Commission before.

6 MR. McNALLY: The only other comment we  
7 would like to make is the very rapid rise in this coverage  
8 for major medical. Increase in the one year has been  
9 100%. If you will notice, in 1959 the coverage is only  
10 one million people. In 1960 it has gone up to two million.  
11 This is a rise of 100% in one year.

12 The other factor there is what Mr.  
13 Cunningham developed, this kind of coverage has only been  
14 available generally since 1958 and it has risen since  
15 1958 from 200,000 to a figure of two million in 1960.  
16 An extremely rapid rise in this kind of coverage. I  
17 think we would like to demonstrate that.

18 COMMISSIONER FIRESTONE: This is a very  
19 useful observation sir. In fact, your information is  
20 very helpful. Would you expect that the rate of one  
21 million per year would continue?

22 MR. CUNNINGHAM: I would think it would  
23 accelerate for a while.

24 COMMISSIONER FIRESTONE: You would say  
25 it would accelerate? That one million would increase  
26 per year rather than decrease?

27 MR. CUNNINGHAM: Yes, I would think so,  
28 sir, definitely.

29 COMMISSIONER FIRESTONE: And what are  
30 your reasons for saying so, sir?







1 MR. CUNNINGHAM: To begin with, we have  
2 to bear in mind that within the last two or three years,  
3 depending on the date on which each province went into  
4 the hospital program whereby the federal authorities  
5 take half the cost, that has lifted a direct burden off  
6 the Canadian people by probably about half the medical  
7 cost that they used to have to meet, so that in devising  
8 these insurance programs now in most of the provinces,  
9 the prepayment plan and the insurance companies are  
10 actually not allowed to duplicate the standard ward level  
11 hospital care that is provided by the province and the  
12 Federal Government, so that the cost of the balance of  
13 the program, which is mostly medical and surgical, is  
14 less than it used to be when it had to include hospital  
15 expenses.

16 COMMISSIONER FIRESTONE: Well, thank you  
17 for those comments. May I now turn to your discussion of  
18 the indigents commencing on page 20: You distinguish, sir,  
19 between two types of indigents: those that are public  
20 welfare cases and those that are, as a rule, self-suppor-  
21 ting but who, on occasion, find it impossible to pay their  
22 medical bills, either in full or in part or other health  
23 care expenditures.

24 The first group we are told is usually  
25 called indigent and the second group is usually called  
26 medically indigent. May I use those two terms in this  
27 discussion and in further questions? Now sir, you made  
28 the observation, and I am just trying to paraphrase  
29 what I understood you to say: that the Chamber is expres-  
30 sing concern about the increasing proportion of national







1 income that is required to meet health and welfare pay-  
2 ments and that concern was due to perhaps as far as  
3 health is concerned to the need to pay more for the  
4 indigents and the medically indigent. Is that correct,  
5 sir?





1 MR. CUNNINGHAM: The concern which we  
2 expressed applied to the expenditures of the various  
3 governments in connection with the welfare services  
4 that pertained exclusively to health. We didn't express  
5 concern anywhere in here about the personal expenditures  
6 that the individual may run up against.

7 COMMISSIONER FIRESTONE: But would you not  
8 say, if I understand you correctly again, that in order  
9 to pay for the requirements of the indigents perhaps  
10 more money has to be spent than is being spent at present?  
11 Would you say that, sir?

12 MR. CUNNINGHAM: Yes. In order to take  
13 care of them as probably they should be taken care of,  
14 yes, definitely.

15 COMMISSIONER FIRESTONE: You say on page  
16 20, if I may quote the last paragraph -- and this refers  
17 to both the indigents and the medically indigents.

18 MR. CUNNINGHAM: Yes.

19 COMMISSIONER FIRESTONE: "It is our view  
20 that the necessary health facilities should be made  
21 available to this group regardless of their inability  
22 to defray the cost of these services...."

23 MR. McNALLY: Exactly.

24 MR. CUNNINGHAM: That is right.

25 COMMISSIONER FIRESTONE: If these payments  
26 are made, they are made by all three levels of government,  
27 these payments have to be financed, where is the money  
28 going to come from to pay for what you describe as indigent?  
29 If, for example, this involves increased taxes, would  
30 the Chamber of Commerce support increased taxes to pay for







1 such health expenditures?

2 MR. CUNNINGHAM: Yes, I think the Chamber  
3 would support any moderate increase in taxes provided  
4 it was consistent with the particular state of the  
5 economy of the government involved.

6 MR. McNALLY: Our position is that in our  
7 view no Canadian should be allowed to suffer medical  
8 illness or accidents because he can't pay for it, and  
9 to the extent that the provinces or municipalities must  
10 increase their budget to take care of these people in  
11 these circumstances, we are prepared to pay for it.

12 COMMISSIONER FIRESTONE: Thank you; this  
13 is a very forthright statement. I thank you.

14 May we now come to the second group which  
15 you call medically indigent, and again I would like to  
16 paraphrase something which I think you did say, and  
17 please forgive me if I didn't understand you correctly.  
18 I understood you to say that most of the indigents  
19 are already on the public assistance roll, and then  
20 you went on to say that there are others which would  
21 need assistance and you explained how these should be  
22 taken care of. Have you any evidence to submit to  
23 the Commission to demonstrate that most of the indigents  
24 are already on the public assistance roll?

25 MR. CUNNINGHAM: What I was referring to  
26 in my introductory remarks was the fact that the medical  
27 care of indigents could be -- you already have a great  
28 body of indigents in Canada who are already on the  
29 public assistance rolls. We enumerate some of them  
30 there. Those who are receiving relief, that is an





1 identifiable group, and these people, when they run  
2 into other need for help, medical expenses, they should  
3 have it. That is what we are advocating.

4 COMMISSIONER FIRESTONE: Really in para-  
5 graph 5 on page 23 you are recommending that the re-  
6 search staff of the Commission ascertain the complete  
7 facts of the situation, and I may say that this is under  
8 way and therefore we don't have the advantage of the  
9 results of surveys which are under way. But we have been  
10 travelling across the country and have been hearing  
11 views expressed in different parts of the country, and  
12 one cannot help but feeling that the number of medically  
13 indigents are more numerous than the number that are  
14 defined as indigents. Now, one cannot make any  
15 assertion on the facts until we have the facts, but  
16 let's assume that our research will show that the  
17 medically indigents are two or three times the number  
18 that are already on the public assistance roll, as you  
19 call it. Would you feel that the medically indigent  
20 should be treated the same way as the indigent, the  
21 medically indigent, including people who are self-  
22 supporting but who lose their jobs and they cannot pay  
23 their medical bills or they include people who continue  
24 to be employed by their income is so inadequate, because  
25 they have a number of children, they cannot pay for  
26 more than the necessities of life, and it may include  
27 farmers in a poor year and have very little income.

28 Now, would you feel that this group of  
29 medically indigents should be treated the same way as what  
30 you define as indigents?







1 MR. CUNNINGHAM: Yes, without any  
2 hesitation.

3 COMMISSIONER FIRESTONE: You have re-  
4 commended for the people in the indigent group a means  
5 test.

6 MR. CUNNINGHAM: Yes.

7 COMMISSIONER FIRESTONE: If this would mean  
8 extending the means test to two or three times the  
9 number of Canadians now subject to the means test, you  
10 would still be in favour of this system?

11 MR. CUNNINGHAM: Yes, sir.

12 COMMISSIONER FIRESTONE: You have made other  
13 recommendations on page 23 saying that in order to  
14 mitigate "catastrophic illness expenditures by normally  
15 self-supporting persons, we recommend the following  
16 amendments to the Income Tax Act." Now, if people  
17 are unemployed and they have large expenditures, they  
18 get medical insurance, in what way would income tax  
19 deductions be helpful? When you have little income  
20 you pay no income tax or very little income tax, and I  
21 am sure the unemployed pay no income tax unless they  
22 have other income. In what way would the income tax  
23 provisions you have recommended help those which may be  
24 in the category of self-supporting but through no fault  
25 of their own being unable to pay excessive medical care  
26 expense?

27 MR. McNALLY: The quick answer to that,  
28 of course, sir, is that if they have no income the  
29 income tax deductions will not help them. When you  
30 indicated those who lose their jobs, this does not





1 necessarily follow. There are those who will be helped  
2 by their organization and there are sickness insurance  
3 plans which provide money to the person off work because  
4 he is ill, and to the extent that these people had  
5 income, we feel that these things would help them.

6 The first one is designed to apply the 3%  
7 floor to what is called a taxable income in the Income  
8 Tax Act, because we feel that at the moment, whether you  
9 have one child or ten children, you get a floor of your  
10 net income before you take off your personal exemptions,  
11 and presumably a person with a larger family would have  
12 a larger deduction for medical expenses.

13 On the other side, in No. 5 it is possible  
14 to encounter catastrophic medical illness, and because  
15 you have not enough income in that year against which  
16 to apply these expenses for deductions, it is our  
17 submission that the amount left over which you were not  
18 able to deduct that year should be applied to the  
19 previous year, or, I should say, in the next five years,  
20 so that over the years there would be a mitigation to  
21 the family through the Income Tax Act in these medical  
22 expenses.

23 COMMISSIONER FIRESTONE: Do I understand  
24 you to say that many people that are covered by, say,  
25 a health care plan, a prepaid medical care plan, once  
26 they become unemployed will continue to enjoy the  
27 benefits of that coverage even though they may be unable  
28 to pay the premiums?

29 MR. McNALLY: No. What I said was besides  
30 the health insurance plan, which covers surgical, hospital





1 and medical care, there are also a number of plans which  
2 provide for the payment of money to people, and these  
3 plans are called sickness insurance plans and they  
4 are really disability wages, another way of putting them.  
5 So these people will have money, even though they are  
6 off work, because they are paying for these other plans.

7 COMMISSIONER FIRESTONE: Would you be in  
8 a position to tell the Commission how many people are  
9 covered in these medical plans?

10 MR. McNALLY: It is in our submission in  
11 the table that is set out on page 7, and the lead in  
12 is "Sickness and Accident Leave Benefit Plans," and it  
13 says:

14 "In Canadian industry, a large majority  
15 of both plant and office employees are employed by  
16 companies where a sickness and accident leave benefit  
17 plan is in operation as is illustrated by Table 2."

18 Now, the sickness and accident leave benefit  
19 plans are plans whereby, when the employee is off work  
20 because he is sick or because he has had an accident,  
21 his salary continues to be paid to him by his company.  
22 In the survey taken there were in the plans in operation  
23 60% reporting units, 36% no plan, and in these plans  
24 it is 83% of employees were covered. So this is the  
25 kind of disability wage plan which we are speaking of.

26 THE CHAIRMAN: Are you able to translate  
27 that into number of persons?

28 MR. CUNNINGHAM: Over a million employees.

29 COMMISSIONER FIRESTONE: Over a million  
30 employees. Over one million employees in Canada







1 covered by this plan which you describe as what?

2 Sickness and Accident Leave Benefit Plan? Is that  
3 what you are saying, sir?

4 MR. McNALLY: Yes.

5 MR. CUNNINGHAM: Well, the Labour  
6 Department made a survey of a little over eight  
7 thousand industries, and employees of these industries  
8 totalled just over a million in number. So that is  
9 the extent of the cover we are talking about.

10 COMMISSIONER FIRESTONE: This coverage  
11 of the survey, it doesn't necessarily mean that the  
12 million people were covered by that plan, and if there  
13 is any doubt about the figures I think it would be  
14 agreeable to you that we refer this matter to the  
15 Department of Labour. Would that be agreeable to you?

16 MR. CUNNINGHAM: Yes.

17 COMMISSIONER FIRESTONE: If we have a  
18 million people covered -- and I doubt if that is the  
19 number; I would consider it is considerably less --  
20 what happens to the rest of the people? After all,  
21 there are over six and a half million people in the  
22 Canadian labour force.

23 MR. TURNER: They are not all likely to  
24 be unemployed at the same time.

25 COMMISSIONER FIRESTONE: It is really only  
26 the minority of people covered by this arrangement.

27 MR. CUNNINGHAM: No, not the minority, the  
28 majority.

29 COMMISSIONER FIRESTONE: The minority  
30 would be covered by the sickness and accident leave





1 benefit plans to which you have referred on page 7?

2 MR. CUNNINGHAM: The Labour Department  
3 didn't survey the whole of employers in Canada, this  
4 is only a sample.

5 MR. McNALLY: Your question started off  
6 by making the assumption that there will be far more  
7 people who are medically indigent than there are  
8 indigent?

9 COMMISSIONER FIRESTONE: That is right.

10 MR. McNALLY: That is correct, and then  
11 you use as an illustration, many of whom may be un-  
12 employed, that was your second assumption, and I inter-  
13 jected and said they will not all necessarily be un-  
14 employed and without funds. That is the point I was  
15 trying to make.

16 COMMISSIONER FIRESTONE: I think you made  
17 your point. The fact remains that there is a large  
18 number of medically indigent which you wish to take  
19 care of in your plan.

20 MR. McNALLY: We don't have any evidence  
21 of the number. The criterion that is used in the  
22 Commission's study, we will use the Commission's study  
23 to see, but in the absence of that we have no information  
24 really.

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1 COMMISSIONER FIRESTONE: Can you give  
2 the Commission some guidance, what you advise that we  
3 should do in defining the medically indigent?

4 MR. McNALLY: Well, there are some  
5 bench marks from which to start. There are some computed  
6 amounts which Canadians are required to spend, in The  
7 Income Tax Act, which is 3% for medical expenses. It is  
8 difficult to say that the figure which would be the  
9 threshold of catastrophe would be double, or triple that,  
10 or something of that order, but that is a bench mark  
11 taken as what is the everyday expenditure by Canadians,  
12 and to look at that in terms of the other budgetary  
13 items in the Canadian household budget, and perhaps a  
14 multiple of that 3% figure, and where you locate your  
15 multiple is, I think, the crux.

16 COMMISSIONER FIRESTONE: We would be  
17 glad to pass this on to our Research staff, who are  
18 engaged in trying to establish some figures.

19 May I now turn to a statement you have  
20 on page 26, the second last line:

21 "The present attitudes of Canadian  
22 governments towards welfare programs  
23 cannot, therefore, continue unless we  
24 are to have a society vastly different  
25 from the one we know today".

26 This, I take it, is a quote from?

27 MR. CUNNINGHAM: Underwriting Canadian  
28 Health, William Loughheed Associates.

29 COMMISSIONER FIRESTONE: Does your  
30 Chamber of Commerce subscribe to this statement?





1 MR. CUNNINGHAM: That was a survey,  
2 as we point out here, that was arranged jointly by the  
3 Canadian Life Insurance Officers' Association and the  
4 Canadian Chamber. It is an independent study. Neither  
5 of the organizations attempted to influence it at all,  
6 and Dr. Lougheed brought out some conclusions. Everybody  
7 didn't agree with it.

8 COMMISSIONER FIRESTONE: I take it this  
9 does not represent official Chamber of Commerce policy?

10 MR. CUNNINGHAM: No, no, it is not the  
11 official policy.

12 MR. KEEPING: I think it is put in as  
13 evidence of our concern with the large bite that the  
14 Government is taking out of the G.N.P. of the country.

15 COMMISSIONER FIRESTONE: For health  
16 and welfare expenditures?

17 MR. KEEPING: For all expenditures.

18 COMMISSIONER FIRESTONE: Can we concen-  
19 trate our thinking on health and welfare expenditures?  
20 An earlier statement you made, Mr. Cunningham, was with  
21 reference to the increasing proportion of our national  
22 income which is required to meet health and welfare pay-  
23 ments. I take it that this is a concern about the propor-  
24 tion of health and welfare expenditures on all levels of  
25 government in relation to either national income, or  
26 gross national product, arising over a period of time;  
27 is that your concern?

28 MR. CUNNINGHAM: That is right.

29 COMMISSIONER FIRESTONE: Well now, sir,  
30 I took your figures in the table on page 43, Appendix G,







1 of close to three billion dollars, and related this to  
2 the gross national product for Canada in 1961, which is  
3 estimated at approximately 37 billion dollars. It gives  
4 you a ratio of government expenditures on health and  
5 welfare as a proportion of G.N.P. of about 8%. Now sir,  
6 you are so concerned with expenditures on health and  
7 welfare rising more rapidly than the ability of the  
8 country to produce, as reflected in the gross national  
9 product?

10 MR. CUNNINGHAM: That is right.

11 COMMISSIONER FIRESTONE: You realize  
12 that our gross national product is expanding? It is  
13 increasing in most years.

14 MR. CUNNINGHAM: Yes.

15 COMMISSIONER FIRESTONE: Would you be  
16 in favour of a policy which would end all increasing  
17 health and welfare expenditures in the light of the  
18 growth of the productive potential and the productive  
19 capacity, of the national income? In other words, as  
20 long as the proportion remains the same, would you be in  
21 favour of such an approach?

22 MR. CUNNINGHAM: I don't know how the  
23 Chamber would react to that. If I might express a view,  
24 that as long as the increasing health and welfare expendi-  
25 tures didn't exceed the rate of increase of health and  
26 welfare expenditures didn't exceed the rate of increase  
27 of the gross national product, or some other suitable  
28 measure, then we would not probably have too much to  
29 worry about, except that we think the proportions are  
30 pretty high right now.







1 COMMISSIONER FIRESTONE: Would you be  
2 in favour, therefore, of reducing the health and welfare  
3 program, or are you content with leaving it at the  
4 present ratio?

5 MR. CUNNINGHAM: You couldn't reduce  
6 them.

7 COMMISSIONER FIRESTONE: Then you would  
8 be in favour of maintaining the ratio that exists at the  
9 moment, is that what you are saying sir?

10 MR. CUNNINGHAM: I would think so.

11 MR. MORRELL: I wouldn't go over the  
12 ratio. You could increase it as fast as the gross  
13 national product increases.

14 COMMISSIONER FIRESTONE: You appreciate  
15 that if we don't get advice from the business community,  
16 how can we offer advice to the Government as to the  
17 proportion that can be devoted to health and welfare  
18 expenditures?

19 MR. CUNNINGHAM: We have pointed out in  
20 a number of places in our brief that we are concerned  
21 with two things. One is that the proportion of the  
22 G.N.P., or the Government revenues, whichever way you  
23 want to put it, that are being spent on health and  
24 welfare benefits now, are alarmingly high, and they show  
25 every indication of increasing at a more rapid rate than  
26 the increase in the G.N.P. for the nation, and that we  
27 regard as a very serious outlook.

28 MR. KEEPING: I don't think we could  
29 express any opinion on the quantum of health and welfare  
30 expenditure without knowing the additional funds that





1 are being expended.

2 MR. McNALLY: And without information  
3 on the other expenditures, such as education and social  
4 welfare.

5 COMMISSIONER FIRESTONE: Are you  
6 including education as welfare?

7 MR. McNALLY: As a social expenditure.

8 COMMISSIONER FIRESTONE: Would you like  
9 to look at Table G. Do you see educational expenditures  
10 included under welfare?

11 MR. McNALLY: That was not the point.

12 MR. MORRELL: If you will recall that  
13 when Mr. Cunningham made his initial summary, he made  
14 the statement that the expenditure of public funds in  
15 one area of welfare makes less available for other essen-  
16 tial needs, such as education.

17 COMMISSIONER FIRESTONE: May I just at  
18 this stage stick to the proportion of health and welfare  
19 expenditures to the G.N.P.? As I understand Mr. Cunning-  
20 ham to say, you feel that this proportion has reached an  
21 alarming proportion?

22 MR. CUNNINGHAM: Yes, I said that.

23 COMMISSIONER FIRESTONE: What is the  
24 implication of your statement? Do you mean that there  
25 should be this ratio of 8% health and welfare expenditures  
26 to gross national product, should be reduced? Is that  
27 what you have in mind, because this is an important  
28 bearing to us. If you feel that health and welfare  
29 expenditure, as a proportion to gross national product,  
30 should be reduced, there will be less room for expansion







1 of a number of programs, including health services. What  
2 is your advice? Do you want to keep the ratio at the  
3 same level? You have already said you do not want an  
4 increase. Would you be content to keep it at the present  
5 ratio, or do you want it reduced?

6 MR. McNALLY: I was going to say that it  
7 is very difficult to do this in this rather mechanistic  
8 way. I think our prime position is this, that we are  
9 willing, and we think it is desirable, that a government  
10 budget should be spent on the requirements of the  
11 Canadian people, to provide for their health and welfare,  
12 and expenditures at all levels of government should  
13 reflect this. Some of the suggestions we are making,  
14 in that the coverage of Canadians by Canadians in the  
15 private insurance field will tend, we think, to reduce  
16 the commitments on the national budget, and to that  
17 extent, if a comprehensive, compulsory, national health  
18 scheme is not recommended, there will not be this pressure  
19 on the social welfare categories of government spending  
20 which would otherwise be. So I don't think we can give  
21 a categorical answer, except to say that we think that  
22 health and social welfare expenditures by government  
23 should be sufficiently large to cover the needs of the  
24 Canadian people, having in mind the fact that we think  
25 most Canadians can take care of their own health needs  
26 by private arrangements.

27 COMMISSIONER FIRESTONE: Well now, sir,  
28 I started out by asking you a very simple and basic  
29 question at the beginning; by asking you whether your  
30 suggestion that a higher level of health services for





1 the Canadian nation didn't mean, in fact, increased  
2 expenditures on health care, and I understood the answer  
3 was yes. We further went on to say that some of that  
4 increase would come from individual spending, and some  
5 of it increased spending by the State, and State you  
6 defined to cover all three levels of government. I am  
7 bringing it to a conclusion in relation to the ability  
8 of the nation to pay, and I am asking you, as businessmen  
9 who have looked at the Canadian economy, that we ought  
10 to be careful in not upsetting this delicate balance  
11 between one type of endeavour, that people call productive  
12 endeavour, and another type of endeavour.

13 We are coming to you for advice, and  
14 we are saying, realizing that governments will have to  
15 spend more, we don't know at this point how much, we  
16 have studies underway and have consulted a lot of people;  
17 the question arises, knowing that we will have to recom-  
18 mend some increase in expenditures, we want to relate  
19 this to the ability of the Canadian economy to produce,  
20 and to afford to pay.

21 Would you be supporting a program that  
22 includes a health and welfare program expansion, sensibly  
23 conceived, and sensibly administered, but which would  
24 keep the relation of health and welfare expenditures to  
25 G.N.P. about the same level?

26 MR. CUNNINGHAM: I would say yes.

27 MR. KEEPING: I would personally say  
28 yes, Mr. Chairman.

29 COMMISSIONER FIRESTONE: Gentlemen,  
30 you have been most helpful, thank you very much.







1 COMMISSIONER McCUTCHEON: It occurs to  
2 me that you may have spoken a little quickly. Supposing  
3 that as the general state of the economy improves,  
4 instead of spending 500 million dollars on unemployment  
5 insurance, we spent 100 million; is your answer that we  
6 take the other 400 million and put it into other health  
7 and social welfare expenditures, or would you not like  
8 to see the absolute and relative amount decreased under  
9 those circumstances?

10 MR. BRADSHAW: We did say that we  
11 thought the present ratio was high, and we should endea-  
12 vour to decrease the ratio, even though there may be  
13 increased expenditures.

14 COMMISSIONER McCUTCHEON: You would  
15 hope that as time went on the ratio might decrease,  
16 rather than increase?

17 MR. BRADSHAW: Yes I would.

18 COMMISSIONER FIRESTONE: Mr. Chairman,  
19 this was not my understanding. My understanding was,  
20 from the two witnesses that have replied to my question,  
21 that as the Canadian economy expanded we could afford  
22 more on health and welfare services. We are not talking  
23 of an exact percentage every year, because it may go a  
24 fraction down, or a fraction above, but over a long  
25 period of time the nation has to plan its program. You  
26 have got to do some planning, and you will need some  
27 overall guidance, and if I understood you correctly,  
28 the guidance which you offered was that a long-term objec-  
29 tive, keeping the ratio about the same, would be the  
30 sort of policy you would endorse?







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1 MR. McNALLY: These are personal  
2 opinions.

3 MR. KEEPING: I would be happy personally  
4 if it could be confined to the same percentage of the  
5 gross national product that it now bears. I would be  
6 happier if it could be reduced below that, commensurate  
7 with providing Canadians with the best in health facili-  
8 ties.





1 COMMISSIONER FIRESTONE: Fine, sir.

2 THE CHAIRMAN: Any further questions?

3 COMMISSIONER STRACHAN: You have stated  
4 that you have 850 community boards of trade; how many  
5 individual members would that represent?

6 MR. MORRELL: About 150 thousand.

7 COMMISSIONER STRACHAN: Those would  
8 represent a slightly lesser number of small and large  
9 businesses but in general that membership represents  
10 management.

11 MR. MORRELL: Perhaps I had better clarify  
12 my answer. You asked for the underlying membership  
13 of the 850 boards and chambers, that is about 150  
14 thousand. The Canadian Chamber is also supported by  
15 some 2,700 companies in Canada both large and small and  
16 we have not made an estimate of those employees of those  
17 2,700 companies. This is another segment of the  
18 membership of the Canadian Chamber.

19 COMMISSIONER STRACHAN: How many different  
20 businesses, large and small, might you represent?

21 MR. MORRELL: Well, some of the 2,700  
22 would be in the 150 thousand.

23 MR. McNALLY: In terms of the size of the  
24 establishment, the number of the employees.

25 COMMISSIONER STRACHAN: No, the number of  
26 members you represent by the 850.

27 MR. McNALLY: The figure that Mr. Morrell  
28 gave was 150 thousand members of local community boards  
29 of trade and chambers of commerce. That is a composite  
30







1 membership in that membership, at the community level  
2 these are mainly, as you would expect, small business  
3 enterprises.

4 COMMISSIONER STRACHAN: And they do re-  
5 present management in general?

6 MR. MORRELL: In general.

7 COMMISSIONER STRACHAN: Have you ever  
8 taken a census of the group as to how willing or  
9 prepared they are to employ handicapped people? You  
10 have mentioned the employment of handicapped people on  
11 page 16:

12 "Employers continue to cooperate in the  
13 placing of handicapped persons in suitable jobs."

14 Have you taken any census as to the number who  
15 would be willing to employ handicapped or have work done  
16 by handicapped in shelter or workshops?

17 MR. McNALLY: We did in developing a number  
18 of years back this policy statement that we have on the  
19 employment of the physically handicapped take a very  
20 small sample survey to indicate the problems, if any,  
21 that people were having in the hiring of the physically  
22 handicapped people. My recollection is, and it goes  
23 back about six years, that the size of the sample was  
24 only about 150 corporations and of these the majority  
25 of them were quite willing to employ physically handi-  
26 capped people. Among those who do in fact employ these  
27 physically handicapped people, they were quite happy  
28 with the performance of the physcial handicapped people  
29 in terms of their attendance, in terms of the quality  
30 of their work, in terms of their morale. This is the





1 only sample survey we have taken and I must stress it was  
2 a rather small one.

3 COMMISSIONER STRACHAN: You mentioned the  
4 difficulties, what are those difficulties?

5 MR. McINALLY: There were some difficulties  
6 in relating the physically handicapped people to the  
7 pace of production. They obviously could not be put  
8 on a machine pace or production pace scheme, they  
9 had to be put in areas where they would be off by  
10 themselves doing skilled work or work that did not  
11 demand physical capacities which are geared to a  
12 production line basis.

13 COMMISSIONER STRACHAN: Are there any  
14 labour relation difficulties?

15 MR. McINALLY: Not that we were able to  
16 discover.

17 COMMISSIONER STRACHAN: What are you doing  
18 to encourage the membership to employ handicapped people?

19 MR. MORRELL: The policy of the Canadian  
20 Chamber is approved in a democratic way, at annual  
21 meetings once a year and this policy has been in the  
22 policy declaration book of the Canadian Chamber for many  
23 years. Each year we correspond with our members urging  
24 the implementation of the policies which are  
25 approved at annual meetings so at least once a year the  
26 policy of the employment of the handicapped is brought  
27 home to at least the 2,700 companies and to the 150,000  
28 members indirectly through the local boards of trade  
29 and Chambers of Commerce.

30 COMMISSIONER STRACHAN: Is anything







1 definite being done by your provincial offices?

2 If I wanted to have a handicapped employed could I go  
3 to any of your provincial offices and ask for those  
4 members or associations who are willing to employ the  
5 handicapped?

6 MR. McNALLY: We would be willing to do  
7 a survey for you if this was the circumstance. They  
8 know in their own community those organizations that  
9 are employing the physical handicapped and they would  
10 be glad, I am sure, to cooperate in surveying the  
11 membership to discover which of the membership would  
12 be willing to employ the physically handicapped.  
13 To that extent they would certainly cooperate.

14 COMMISSIONER STRACHAN: In my discussions  
15 with some individuals who are concerned with handicapped  
16 persons this apparently is not as simple as all that.  
17 You have mentioned an educational program in respect  
18 to health; how do you feel that may be carried out,  
19 at whose instigation and whose expense, whose re-  
20 sponsibility?

21 MR. CUNNINGHAM: This is a rather general  
22 type of recommendation that there should be such a  
23 thing. We had in mind that the existing instrumentality  
24 should be used for the persistent dissemination of  
25 advice, information and so on in connection with the  
26 attaining of good health to the Canadian people, news-  
27 papers, magazines, radio, television, anything at all  
28 to get the message to the Canadian people as to the  
29 best way in which they can look after their own personal  
30 health requirements.







1 COMMISSIONER STRACHAN: All of those  
2 you have mentioned are recognized as rather expensive  
3 mediums, who should bear the expense?

4 MR. CUNNINGHAM: That could be shared,  
5 a lot of it probably would be paid for privately.  
6 Take, for instance, the monthly magazine or quarterly  
7 of the Health League of Canada, that sort of thing in  
8 the opinion of some of us is excellent informational  
9 material to come before the Canadian people. The  
10 Health League of Canada is supported almost entirely  
11 by public subscription.

12 COMMISSIONER STRACHAN: That is a very  
13 limited subscription.

14 MR. CUNNINGHAM: We have in mind too, these  
15 exercises that are recommended by the Air Force, 5BX  
16 and XBX, that sort of stuff.

17 COMMISSIONER STRACHAN: You have suggested  
18 that faculties in respect to health, medical and dental  
19 should be increased in number. Now, to increase their  
20 number or size the teaching personnel becomes quite  
21 a problem. Have you any suggestions as to any  
22 liberal allowances that might be made towards qualifying  
23 that personnel?

24 MR. CUNNINGHAM: We did make certain  
25 recommendations in here regarding the more general  
26 treatment by way of allowances of one kind or another.  
27 We had in mind medical students primarily in the way  
28 of scholarships, bursaries and so on and so forth.  
29 We mention loans, for instance, to students. I know  
30 in the province of Quebec the provincial government has





1 an arrangement for making loans to university students  
2 to assist them -- interest free loans. Graduate  
3 societies generally have an arrangement of that kind  
4 and individual philanthropists have established  
5 scholarships and bursaries to take care of this sort of  
6 thing. We feel with the necessary publicity, that  
7 the increase in these bursaries and scholarships and  
8 general financial arrangements to assist students will  
9 be forthcoming from industry and from private in-  
10 dividuals and if the various levels of government can  
11 help that would be all right too.

12 COMMISSIONER STRACHAN: Would you say what  
13 you have stated would be a means of attracting an in-  
14 creased number of qualified people into the Canadian  
15 medical manpower force?

16 MR. CUNNINGHAM: That is what we would hope.

17 COMMISSIONER STRACHAN: This would be the  
18 means by which you would do it?

19 MR. CUNNINGHAM: Yes.

20 COMMISSIONER BALTZAN: Mr. Cunningham, the  
21 hour is getting late and I have not too many questions.  
22 I have one here and more of an explanation that I would  
23 refer to what is a rule of thumb sort of dictum to the  
24 effect increased health services have improved the health  
25 of the nation and nearly everybody here knows that the  
26 answer there is yes. I question a little bit the  
27 total validity of that and place this as a corollary;  
28 if the people badly disregard or abuse the health  
29 privileges, the health rules, could that not in itself  
30 considerably cancel out the facts which are provided by







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1 extensive health services? In other words, while the  
2 answer to the first is positive, the answer to the  
3 second would possibly what?

4 MR. CUNNINGHAM: I suppose it could. I  
5 have also seen the statement made that we have to  
6 spend a tremendous amount of money to be successful  
7 in preventing a lot of sickness and accidents and  
8 resulting in people getting to old age you will get  
9 tremendous sickness bills in the older age group and  
10 the overall cost will increase. I do not believe  
11 that but that statement was made in the British Medical  
12 Journal, as a matter of fact.





1 COMMISSIONER BALTZAN: Just one thing, it  
2 is a little discouraging when you look at it and  
3 you quote the Bell Telephone Company, page 3 second  
4 last paragraph "...by the time the individual  
5 is ready to enter the career field, it is indicated  
6 that only about 60 per cent of Canadians are found  
7 to meet completely satisfactory standards of health."  
8 This is some sort of a black label in the literal use,  
9 not commercial on the health condition of Canadians.

10 I am wondering if it actually is realistic.  
11 First, one must define what is complete health and  
12 second what requirements tend to interfere with one's  
13 ability to live and work and produce. As, for  
14 example, a man with one eye, myopic individual,  
15 they can be productive. They can enjoy life. They  
16 can be occupied and this is really not a blemish on  
17 the whole -- statistically that the health of the  
18 Nation is as desperate-looking as this figure may  
19 sound. You agree with that?

20 MR. CUNNINGHAM: Yes. When these figures  
21 were presented to us, we were rather amazed and we  
22 made further inquiries. We have a presentation  
23 from the Medical Director of the Bell Telephone  
24 Company which indicates just exactly what they meant.  
25 When they have applicants for jobs -- these will be  
26 males and females -- for clerical work, for technical  
27 work and for work in the field, and so on, they put  
28 them in -- the medical examination puts them in  
29 any one of three categories. There is one category,  
30 very very small proportion of them are found to be





1 in such a bad state of health they won't hire them  
2 at all. Then the largest group go into the sixty  
3 per cent category where they are taken on without  
4 question.

5 They do not pay attention to the odd bit  
6 of dental caries; that is a whole in your teeth.

7 COMMISSIONER BALTZAN: In other words, you  
8 would say that measure is related to the job  
9 performance actually?

10 MR. CUNNINGHAM: It has something to do  
11 with it, yes, but the group in which 37 per cent of  
12 their employees, of their prospective employees drop  
13 include candidates -- here is what he says:

14 "...with health defects which  
15 are correctible in character and  
16 which are either compatible with  
17 their being employed at once with  
18 the understanding that these health  
19 defects will be cleared up within  
20 the specified period of time or  
21 else the defect is of such a  
22 serious nature that the employment  
23 is delayed until the defect has  
24 been successfully corrected and  
25 the correction confirmed by re-  
26 examination."

27 And he says some 34 to 35 per cent "of our applicants  
28 are in this particular category at the time of their  
29 initial examination". And examples of what he  
30 is talking about are those that are found to have







1 anemia of the secondary character; those who are  
2 over-weight; have marked teeth impairment, defective  
3 vision and minor skin disorders. It is endless.

4 MR. McNALLY: This is being used Dr. Baltzan  
5 in the context of preventive medicine and for the  
6 context of the definition of health that we set up  
7 which means the optimum physical, mental and social  
8 efficiency and well-being and there are only 60  
9 per cent of the people that go into the Bell fulfill  
10 that category and the only reason we put it in there  
11 is to indicate that a lot of these things are  
12 preventable and that preventive care would probably  
13 increase that figure with the Bell and they claim  
14 it is representative because they have checked among  
15 a number of firms in Montreal and have checked this  
16 with the AT & T system in the United States. If  
17 we were able to get preventive work done those  
18 figures would not show up the way they have in terms  
19 of our definition of health which is the maximum and  
20 optimum amount of health that we think the Canadian  
21 people should have.

22 COMMISSIONER BALTZAN: In other words,  
23 this is not actually an estimate of the health of  
24 the Nation. It is out of context?

25 MR. McNALLY: It is an illustration of the  
26 amount of people that come into a hiring situation  
27 and what they find. That is here as an illustration.  
28 There should be more preventive work done before  
29 these candidates get to employment situation.

30 THE CHAIRMAN: Thank you. Miss Giard?





1 COMMISSIONER GIRARD: In the light of  
2 various recommendations in this report, what do you  
3 say is the future role of the voluntary health  
4 agencies? I see you have not given very much thought  
5 to voluntary health agencies. You do mention them.

6 MR. CUNNINGHAM: These are agencies that  
7 were listed in one of our appendices.

8 COMMISSIONER GIRARD: All voluntary health  
9 agencies in Canada.

10 MR. CUNNINGHAM: Under the Welfare Council,  
11 Red Cross?

12 COMMISSIONER GIRARD: Nursing agencies,  
13 welfare and health agencies.

14 MR. CUNNINGHAM: I am quite sure I can speak  
15 for the Chamber in saying we expect that they will  
16 continue and flourish; still be a need for them and  
17 their services, without question.

18 COMMISSIONER GIRARD: Do you see any  
19 instances where some of their functions would be taken  
20 over by other agencies in prepaid plans or something?

21 MR. CUNNINGHAM: I do not think so.  
22 Probably there is a need for some cooperation in the  
23 fields which involve research, and that sort of  
24 thing. There may indeed be a certain amount of  
25 duplicating and over-lapping. That situation may  
26 improve but as far as their existence is concerned  
27 I would think there would continue to be a need,  
28 a real need for them.

29 COMMISSIONER GIRARD: In many instances,  
30 Community Chests are not reaching their goals or their







1 optimum.

2 MR. CUNNINGHAM: I know.

3 COMMISSIONER GIRARD: Do you think it is  
4 going to hamper the role of the voluntary health  
5 agencies? Are they going to be able to continue in  
6 the same manner as they have been in the past?

7 MR. CUNNINGHAM: I don't see why not.

8 COMMISSIONER GIRARD: Can you give us any  
9 opinion why you think that Community Chests are not  
10 meeting their goals?

11 MR. KEEPING: I certainly feel there is a  
12 place for certain voluntary agencies. I do not think  
13 they should necessarily be taken over by some other  
14 organization. I think that some of them have fulfilled  
15 and are fulfilling a very valuable function; are  
16 performing it well, extremely economically and I  
17 think in any developments in the future very serious  
18 consideration should be given to continuing voluntary  
19 agencies. It should be borne in mind voluntary  
20 agencies have benefited and do benefit and a very  
21 tremendous amount of voluntary management and aid  
22 is given gratuitously and generously by citizens and  
23 I think there is a definite role for certain of them  
24 anyway. It is undoubtedly true that some of them  
25 do experience difficulty in having sufficient funds  
26 to perhaps develop their services as far as they  
27 should be developed.

28 I think there is possibly a role for  
29 Government to play in some of these -- in any  
30 extension or further development of services but I





1 feel strongly myself that certain of the voluntary  
2 agencies, the ones I am connected with, there is  
3 definitely a role for them to fill in the future.

4 THE CHAIRMAN: Thank you very much Mr.  
5 Bradshaw, Mr. Cunningham, gentlemen. As I said  
6 at the beginning when you had concluded your  
7 statement Mr. Cunningham this brief is one that  
8 contains a great deal of very valuable information,  
9 valuable suggestions and will have our serious  
10 consideration.

11 MR. CUNNINGHAM: Thank you very much.

12 MR. BRADSHAW: Thank you sir for letting us  
13 come here and express our thoughts. We hope that  
14 the brief we have given you will be helpful.

15 THE CHAIRMAN: We are going to rise for a  
16 few minutes and then continue with Dr. Jeffrey's  
17 submission.

18 ---Short Recess.

19 THE CHAIRMAN: Ladies and gentlemen, if we  
20 may come to order we will proceed. Dr. Jeffrey?

21 DR. JEFFREY: Yes.

22 THE CHAIRMAN: I am very grateful to you  
23 for remaining.

24 DR. JEFFREY: It is a pleasure. I have  
25 enjoyed this previous session. Mine will be very  
26 dull.

27 MR. HALL: Mr. Chairman, members of the  
28 Commission, the next submission is that of Dr. F.W.  
29 Jeffrey who is a member of the Pediatric Centre in  
30 Ottawa. Dr. Jeffrey would you assist the Commission





1 by explaining and discussing generally the objective  
2 of forming a pediatric centre, the method of those  
3 operations, the advantages which might accrue both  
4 to patients and the physicians through medical  
5 group practice and the difficulties faced and the  
6 operating economics that might be achieved and any  
7 other relative information that you might have.

8 DR. JEFFREY: Mr. Chairman I see by the  
9 agenda that this is to be a verbal statement but I  
10 am afraid I haven't that type of mind. It is not  
11 well organized. But if I can be permitted to refer  
12 to my notes, or even read them, I would appreciate  
13 it very much.

14 I understand that my function at this  
15 hearing is purely informative and I understand that  
16 you have not too much information about group  
17 practice, official information?

18 THE CHAIRMAN: We are anxious to get  
19 particularly the practitioner's viewpoint and  
20 particularly one such as yourself.

21 DR. JEFFREY: I intend to be very frank  
22 and explain everything that we do in the pediatric  
23 centre and I will describe our partnership first.

24 Paediatric Centre is a partnership of six  
25 certified paediatricians bound by a partnership  
26 agreement. We have been in operation since July 1st,  
27 1950, which is approximately twelve years.

28 Our objectives in establishing the  
29 partnership:

30 1. To provide better paediatric care to our







1 patients.

2 2. To reduce the physical, mental and  
3 emotional strain that is inevitably  
4 experienced by all busy paediatricians  
5 practicing alone. I would like to  
6 emphasize that point.

7 3. To provide a greater measure of  
8 security for the participating  
9 doctor in terms of volume of work  
10 and remuneration.

11 4. To achieve certain economies in  
12 operating expenses.

13 I propose to discuss paediatric centre  
14 really under four headings: the medical organization,  
15 facilities available, financial structure,  
16 organization and then advantages and disadvantages  
17 to the patients and the same to the doctors. First  
18 under medical organization we maintain three  
19 The main or head office in the centre of the city  
20 and two branch offices, one in the west end and one  
21 in the east. I think it is rather unusual in the  
22 practice of medicine for partnership practice.  
23 Second all accounts, business files, medical charts  
24 are kept in the main office. I might add, when a  
25 physician has an office in a branch office he is  
26 responsible for taking the charts for that particular  
27 day out with him, or they are sent out for him.





1 Each doctor is allocated specific  
2 periods, either afternoon or morning, in all three  
3 offices for the conducting of his office practice. All  
4 office appointments are made through the main office.

5 Each partner conducts his own private  
6 practice essentially as if he were practising alone.

7 All of us conform in general to a  
8 uniform pattern of practice, partially because of the  
9 similarity of our paediatric training and partially  
10 because of our intimate contact with each other. How-  
11 ever, each doctor has the privilege of conducting his  
12 practice as he sees fit.

13 Any procedures or routines developed  
14 by one doctor are available to all of his partners.  
15 Of course, many of these procedures are the product of  
16 the combined thinking of the entire group. Partners  
17 can discuss their more complicated medical cases and  
18 problems with any or all of the group.

19 Each doctor is obligated by our partner-  
20 ship agreement to take a vacation each year, the minimum  
21 and maximum duration of which is specified. However,  
22 holidays have been determined by mutual agreement and  
23 we have an undertaking that there must not be too many  
24 partners away at one time and particularly for prolonged  
25 periods.

26 Over weekends two of the six doctors  
27 are on duty for urgent calls. This assignment is on a  
28 rotating basis. This same system could be used for  
29 night calls, but as yet has not been instituted.

30 Practising from three widely separated







1 offices has developed for each partner a large practice  
2 spread over the entire city.

3 THE CHAIRMAN: At this point, each  
4 doctor has his individual patients?

5 DR. JEFFREY: Yes, we have our indivi-  
6 dual panel patients.

7 During epidemics this creates a problem.  
8 When the demand for house calls is heavy, the doctor  
9 finds it very difficult to cover the entire city and  
10 suburbs each day. We have considered zoning our house  
11 calls during these emergencies, each of us being allo-  
12 cated to a specific district. We feel that our patients  
13 might accept this arrangement for two reasons:

14 First, most patients have had some  
15 contact with all members of the group during holidays  
16 and weekends, so they are known to them.

17 Second, they would be assured of more  
18 prompt service. Zoning may never become necessary  
19 because of a developing trend in paediatric practice.  
20 We have experienced over the past few years a gradual  
21 reduction in the demand for house calls, with a comparable  
22 increase in requests for office calls. I am not sure  
23 that we have an adequate explanation for this changing  
24 trend and I imagine that the Commission is better  
25 informed on this matter than Paediatric Centre. We  
26 have personal viewpoints on this, but I don't know that  
27 they are too authentic.

28 In Paediatric Centre patients have the  
29 privilege of transferring from one doctor to one of his  
30 partners - although we try to discourage this practice -





1 it is surprising how seldom it occurs.

2 Is the Commission interested in knowing  
3 what is involved in terms of personnel in establishing  
4 a practice or not?

5 THE CHAIRMAN: Not in its detail but  
6 in the kind of organization.

7 DR. JEFFREY: There are one or two  
8 points which may be of interest. I will enumerate a  
9 few of the more important.

10 We maintain three offices all similarly  
11 planned and equipped.

12 Our staff includes:

13 Two nurses working a seven-and-a-half  
14 hour day - 5-day week;

15 Five nurses working a four-hour day -  
16 5-day week;

17 One nurse working Saturday mornings;

18 Two physiotherapists;

19 One secretary;

20 Four final-year students from High

21 School of Commerce working for two

22 hours after school, which is an inno-  
23 vation which we appreciate very much.

24 They can do a lot of the filing and  
25 taking out medical charts and preparing them for the  
26 next day's medical office. They do a lot of work which  
27 would have to be covered by more expensive personnel.

28 Each doctor uses three completely  
29 equipped examining rooms. The patients remain in the  
30 examining room throughout the complete office appointment.





1 They are not transferred to a consulting office to  
2 receive their instructions - and this differs to the  
3 general practice in medicine. On occasions when the  
4 presence of the child is undesirable, he is transferred  
5 to the waiting room or an empty examining room.

6 Each doctors maintains a trunk line of  
7 two 'phones in his home and conducts a telephone consul-  
8 tation between 8 and 9 a.m. each morning. I might say  
9 that in a partnership of six doctors we have 19 'phones,  
10 which may give you some idea as to the extent that the  
11 'phone is used in paediatric practice.

12 The main office has a trunk line of  
13 five 'phones, one of which is for outgoing calls only.  
14 Two registered nurses are required to man these 'phones  
15 throughout the complete office day. They make appoint-  
16 ments, record requests for house calls and 'phone calls  
17 for all doctors, supply advice with regard to minor  
18 paediatric problems, etc. They also transfer appropriate  
19 calls to the accounting office and the secretary, and I  
20 might say that our secretary is involved entirely with  
21 insurance, it seems to be with us; our insurance problems  
22 probably take up half a day.

23 Each branch office has an unlisted tele-  
24 phone which is used only for communicating with the  
25 main office and for outgoing calls.

26 One of our group has had an additional  
27 two years' training in paediatric cardiology. Special  
28 equipment, including electrocardiograph and fluoroscope,  
29 has been installed for his use.

30 In regard to the facilities of







1 Paediatric Centre, we use instruction sheets more than  
2 most doctors; we are very liberal in their use. We  
3 find it cuts down our time, and also I think that the  
4 parents themselves when they get home and get an oppor-  
5 tunity to read them, they are more familiar with the  
6 instructions we have given them and there is not so  
7 much 'phoning back to confirm information we have given  
8 them.

9 Now, financial organization. The  
10 relationship between Paediatric Centre and the Paedia-  
11 tric Realty Company requires explanation.

12 Paediatric Centre is a partnership to  
13 which additional members can be added. The partners  
14 own their cars but none of the equipment that they use  
15 in the practice of medicine.

16 The Paediatric Realty Company has as  
17 its stockholders, each owning an equal number of shares,  
18 the five original members of the Paediatric Centre.

19 This realty company owns two of the  
20 buildings in which the partnership practises and leases  
21 a third office.

2 22 The realty company then rents to Paedia-  
23 tric Centre these three offices, completely furnished,  
24 equipped and staffed, and I mean nurses and clerical  
25 staff.

26 The realty company pays all bills  
27 incurred by Paediatric Centre, that would be telephone  
28 charges, stationery, postage, supplies, drugs.

29 The realty company pays personal bills  
30 of partners that are tax deductible (car expenses,





1 medical journals and text, medical society fees, and  
2 suchlike). These are charged against each doctor's  
3 individual expense account.

4 The realty company charges Paediatric  
5 Centre a nominal fee for administration services.

6 Now, the realty company is completely  
7 divorced from the partnership for two reasons, and the  
8 first is:

9 That as a realty company the partners  
10 can participate collectively in land holdings without  
11 becoming involved in the dower rights of wives that  
12 complicate property holdings of a partnership.

13 Second, the partnership can be expanded  
14 without necessarily implicating the realty company; we  
15 can take additional partners in without absorbing them  
16 into the realty company. Some may want to do it and  
17 others may not be in a financial position at the time  
18 or may not wish to do it.

19 Now, the method of allocation of  
20 profits to each partner, and if there is anything that  
21 is not clear I hope I am interrupted.

22 Each doctor is credited with the total  
23 charges for all services that he has provided to both  
24 his own patients and those of his partners.

25 Monthly statements are prepared indica-  
26 ting the total fees billed by each doctor for that  
27 month. The doctor is allowed a monthly billing allowance  
28 against his profits for the year of any amount up to  
29 half his fees billed for that particular month.

30 At the end of each fiscal year a







1 statement of profits is prepared. This is determined  
2 as follows:

3 From the total receipts is deducted  
4 the sum total of all expenses incurred by the partner-  
5 ship (excluding the doctor's personal expenses). This  
6 sum of money is divided among the partners in proportion  
7 to the fees billed by each doctor for that year. The  
8 partner must then reimburse the realty company from his  
9 profits for his personal tax deductible expenses that  
10 have been paid for him during the year.

11 Now, advantages to patients of Paedia-  
12 tric Centre. When a patient's doctor is not available  
13 because of illness, holidays, professional meetings or  
14 possibly a busy schedule, the patient has the assurance  
15 that one or more of the partners will substitute, and  
16 when necessary can refer to the child's medical file  
17 for pertinent information.

18 Now, patients have three widely separated  
19 offices from which they can choose the most convenient  
20 for their office calls. Patients receive medical  
21 services that have been developed through the pooling  
22 of knowledge and experience of six qualified certified  
23 paediatricians. Patients can be provided with a more  
24 complete range of services in the Centre, because we  
25 are in a position to acquire the equipment and personnel  
26 for this purpose. I don't know; I suppose I should  
27 elaborate on that a bit inasmuch as practising in a  
28 group, we can provide equipment or consider buying  
29 equipment which, if you are in an individual practice,  
30 you cannot consider when you consider the use that that





1 equipment will receive. So that practice in a partner-  
2 ship is an advantage, and also we can attract to our  
3 group ancillary services. So we can provide in a large  
4 partnership a more complete service.

5 Patients have the opportunity of  
6 changing to another paediatrician in the group and  
7 having the complete medical file transferred to that  
8 doctor. I think that is an advantage. Those patients  
9 that are dissatisfied with one, they don't seem to  
10 consider it too embarrassing, most of them are prepared  
11 to accept another in the group, and, of course, there  
12 is access to the file, whereas in the individual prac-  
13 tice the file does not follow the patient and sometimes  
14 the patient is too embarrassed to ask the original  
15 doctor for it.

16 Now, disadvantages to patients of  
17 Paediatric Centre. With our type of operation it is  
18 impossible to allocate to each doctor one specific  
19 nurse who will be responsible for his practice alone.  
20 This may be a disadvantage to patients, in that they  
21 have no one nurse, familiar to them, with whom they can  
22 discuss minor paediatric problems. It is possible also  
23 that patients may encounter a more impersonal attitude  
24 on the part of nursing and clerical staff. I don't  
25 know that this actually occurs. It is one of the things  
26 we have to guard against in our practice. We are trying  
27 to exercise some control over it. It is difficult, but  
28 it is an advantage to us where a patient - and I have  
29 been in practice as an individual for a number of years  
30 before being in this partnership - if a patient came to







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1 know a nurse particularly well they were calling her  
2 continually for minor advice that they should have  
3 solved for themselves, and, needless to say, it was  
4 taking up time and it was causing us concern.  
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2. During two out of every three week-ends, patients may find their own doctor not available and must accept the services of one of the two paediatricians on duty. (This is a very doubtful disadvantage because paediatricians working a seven day week may become sufficiently fatigued both mentally and physically that it reflects in their attitude and standard of care)

#### ADVANTAGES TO PARTICIPATING DOCTORS

1. A doctor can enjoy time away from his work (during holidays, illness and meetings) knowing that his practice will be adequately covered and returned to him intact when he resumes practice, and that his absence does not reflect in his operating expenses. Now, this is very important to us.

2. During a doctor's absence there is no appreciable loss in revenue to the partnership and it provides the opportunity for the younger and less well established members of the partnership to add to their incomes, by accepting the bulk of the calls.

3. Each doctor has the privilege of using any procedures, routines, instruction sheets, etc., developed by any of his partners -- of course many of the methods used in our office have been developed by our combined efforts.

4. Each doctor can discuss any of his difficult medical cases with any one or all of his partners, and this has possibly a monetary disadvantage in reducing the number of official consultations, which may under our existing circumstances be an





1 advantage to the patient, but if insurance schemes ---

2 THE CHAIRMAN: You don't regard that as a  
3 referral?

4 DR. JEFFREY: Yes, they are not referred  
5 officially. We have the advantage of our partners  
6 and using it without bringing in someone on an  
7 official consultation.

8 In theory, a group should operate more  
9 economically than an individual doctor. However, these  
10 economies can be achieved only if adequate controls  
11 are exercised. Some reduction in cost of supplies  
12 can be expected because of ordering in large quantities.  
13 The pooling of expenses in group practice allows us  
14 to buy equipment that a paediatrician practicing  
15 alone, could not consider because of the cost as  
16 related to the use it would receive - x-ray,  
17 electrocardiograph, accounting equipment, etc. and  
18 I have already mentioned this, so that I will not  
19 refer to it again, but I might say that such a capital  
20 expenditure should pay for itself by providing a more  
21 complete and more efficient service to patients.

22 6. A large partnership of paediatricians  
23 can expand the services they provide to include, as  
24 I have already mentioned, allergy, psychology,  
25 cardiology, etc.

26 7. As a member of a large partnership,  
27 you are stimulated by the intimate contact with  
28 qualified competent confreres. This fosters the  
29 maintenance of a high standard of medical care  
30 within the group.







1           8. A participating physician's economic  
2 position is more secure because he has partners to  
3 assist him in developing and maintaining an adequate  
4 practice. If circumstances demand him or allow him to  
5 reduce his practice, he can refer patients to his  
6 partners. No matter how small a practice he maintains,  
7 he will still enjoy all the privileges of a well  
8 equipped and staffed office.

9           DISADVANTAGES TO PARTICIPATING DOCTORS

10          1. There is some risk in acquiring a partner  
11 who becomes incompatible because of a change in his  
12 personal attitude or even because of incompetence --  
13 I would like to emphasize the importance of screening  
14 candidates very carefully, which we do in our own  
15 group - Paediatric Centre has experienced no problem  
16 in this regard in our twelve years of operation.

17           Of course, resignation of an incompatible  
18 partner can be demanded, but such action would be taken  
19 only after a prolonged period of discontent when it  
20 became obvious that the situation was unsalvageable.

21          2. The partnership agreement makes it  
22 difficult for a dissatisfied partner to withdraw from  
23 the group.

24          3. One is obligated to abide by the majority  
25 decision in matters of major policy -- e.g. staffing  
26 policies, accounting procedures, equipment, time  
27 and duration of holidays, attendance at meetings, etc.

28          4. Some carelessness with regard to the  
29 use of supplies and equipment may be experienced because  
30 of the pooling of office overhead.





1 I am not too sure, but it is an obvious  
2 disadvantage, but I don't know that it occurs in our  
3 group. We all try to consider this partially, because  
4 paediatrics are I suppose in the lower income group  
5 as related to other specialities, so we are thinking  
6 of our economies considerably.

7 5. A patient who wishes to discontinue the  
8 services of one paediatrician may be too embarrassed  
9 to transfer to one of his partners and will choose a  
10 new doctor outside the group. Now this is a calculated  
11 risk but we have the impression that this occurs very  
12 infrequently in our practice.

13 And, ladies and gentlemen, I think that is  
14 all the information that I have prepared for you,  
15 but if I can elaborate on any of these points, or  
16 if there are any questions that I can answer, I will  
17 be only too pleased to.

18 CHAIRMAN: Thank you very much, Dr.  
19 Jeffrey. You were kind enough to provide me with a  
20 copy of the memorandum from which you were reading.  
21 We will make this Exhibit 189.

22 ---EXHIBIT NO. 189: Memorandum read by  
23 Dr. Jeffrey.

24 THE CHAIRMAN: Dr. Jeffrey, is your practice  
25 practice?

26 DR. JEFFREY: Yes, essentially an urban  
27 practice. We unfortunately have to go outside the  
28 city limits, and we attract to us a fair segment of  
29 the population, but purely on an office call basis.

30 THE CHAIRMAN: Have you any comments to make,





1 observations, on how a group practice would operate  
2 in a rural community which is perhaps a much more  
3 difficult area to service, either by individuals,  
4 certainly by individuals. We are trying to find out  
5 if group practice may be a solution in rural areas.  
6 Now, I am not only talking about paediatric practice,  
7 but a group practice.

8 DR. JEFFREY: I have been approached by  
9 doctors in small communities, and I am assuming you  
10 are thinking in terms of populations of 25,000?

11 THE CHAIRMAN: No, I am thinking right out  
12 into small places.

13 DR. JEFFREY: Well, if it is a very small  
14 place, of course they are restricted to one physician.  
15 If you are in a medium sized community, you may have  
16 four or five who are essentially general practitioners.  
17 I have been approached in this regard, and I would  
18 feel that it would be very successful. Of course,  
19 there would be a terrific amount... someone has to take the  
20 initiative in the first place, which is necessary,  
21 and it is time-consuming in establishing it. There  
22 is a lot of negotiating. You have to approach your  
23 partners, and set it up, but in a small community  
24 of four or five doctors, I see no reason why these  
25 people, all in general practice....there is no call  
26 for a specialist...at that level, they should be able  
27 to practice as a group.

28 THE CHAIRMAN: Do you see that in an area of  
29 that kind, that would require the services of four  
30 or five doctors, you say general practitioners, that the







1 group practice might make a place for one or more  
2 specialists within the group?

3 DR. JEFFREY: It might, a surgeon, possibly,  
4 provided they had the facilities, which they probably  
5 would not have at that level. You see, the general  
6 practitioners of today are much better qualified than  
7 they used to be in handling the broad field of medicine,  
8 so that they don't require, I don't think, so much  
9 specialist consultation work as they did in the past.  
10 I think that they are using us as much, but my  
11 experience over thirty-five years is that the general  
12 practitioner today knows much more medicine than they  
13 used to. The difficulty in a group of five in a  
14 small community would be the incompatibilities, I  
15 have mentioned. I think it would be very difficult,  
16 because medical men are individualistic. A lot of  
17 them would prefer to be responsible to themselves  
18 only, rather than a group. They are sort of masters  
19 of their own destiny, and they might dislike having  
20 to conform to a pattern that has been established by  
21 a majority decision. They will do that in private  
22 practice, but when it comes to organized medicine --  
23 they are perfectly prepared to accept the majority  
24 decision, or at the hospital level, but when it comes  
25 to the personal, private practice of a physician,  
26 many of them would, oh, I think that they would be  
27 a little discontented possibly, working in a group,  
28 so that would be one point that would have to be  
29 considered.

30 THE CHAIRMAN: Your concept at the moment of





1 a group practice is that all members of the group  
2 live in the one community?

3 DR. JEFFREY: I would expect so.

4 THE CHAIRMAN: Have you given any thought  
5 to a group that would be dispersed over a rural area,  
6 in several communities say, with a central location,  
7 and four sort of ---

8 DR. JEFFREY: Satellites

9 THE CHAIRMAN: Satellites, yes?

10 DR. JEFFREY: I don't know how it could  
11 function. Everything has to be centralized. I suppose  
12 they could be in a large area, and create a team that  
13 could serve the outlying areas. That could be a  
14 possibility. I am not qualified, this is a personal  
15 viewpoint.

16 THE CHAIRMAN: Are you familiar with Dr.  
17 Ecclestone's group practice in the rural area in  
18 upstate New York, Huron County?

19 DR. JEFFREY: No.

20 THE CHAIRMAN: Which is of the kind that I  
21 am just mentioning, that is with a central location  
22 and a number of doctors in communities that will  
23 ordinarily only support one doctor, but grouped  
24 together for the practice of medicine covering the  
25 area of perhaps one of your rural communities in  
26 Ontario?

27 DR. JEFFREY: I haven't given that any  
28 thought. I think that someone should give that some  
29 consideration. On the surface it sounds rather  
30 attractive. I am thinking of the patient.







1 THE CHAIRMAN: We talk of perhaps affording  
2 to everybody in Canada as much as possible the  
3 opportunity to have access to proper health services,  
4 and the moment we go out into the rural areas it  
5 sort of breaks down, unless we can find a way of  
6 establishing some comparable standard of practice,  
7 comparable both in quality and accessibility.

8 DR. JEFFREY: Have I a minute to expound on  
9 this?

10 THE CHAIRMAN: Yes.

11 DR. JEFFREY: I was wondering whether  
12 possibly a team could be the solution. I don't know  
13 the operation in northern New York, but would it  
14 be possible to establish a group and have a team  
15 serve the outlying areas? As I have mentioned,  
16 the trend in paediatrics, I think, is possibly  
17 general now. That there is less demand for house  
18 calls. In other words, if these doctors are  
19 established as a nucleus, the people in the rural  
20 areas have sickness, it either goes to hospital or  
21 could be brought into a doctor's office, provided  
22 he has isolation facilities. We find in paediatrics  
23 that this is occurring in the States, that people  
24 are prepared to bring their sick children into  
25 doctors' offices more than they ever did. We feel  
26 that the mothers of today have more confidence in  
27 this. They feel assured that their child is going  
28 to live, no matter what he has, and because of that  
29 they delay possibly in demanding an office call, and  
30 as I say, are prepared to bring them in. If that





1 was true in a rural practice, you would expect the  
2 people who could be served by a team where they  
3 could come out and do the office work, or a lot of  
4 it, would not have to be expected to make house  
5 calls all throughout this area. They might be  
6 able to do it on a zoning basis, but I hope the  
7 Commission establishes some committee to study this.  
8 It sounds very attractive.

9 COMMISSIONER BALTZAN: Thank you very much,  
10 Dr. Jeffrey, for giving us the benefit of your  
11 experience. Where is your major concentration of  
12 the essential diagnostic facilities?

13 Dr. Jeffrey: In the main office, the main  
14 office.

15 COMMISSIONER BALTZAN: And the satellite offices  
16 refer them back to your main office?

17 DR. JEFFREY: That is right.

18 COMMISSIONER BALTZAN: Have the doctors  
19 in these branch offices much in the way of equipment  
20 for diagnostics?

21 DR. JEFFREY: Well, we have for all the  
22 usual type of office practice, we have everything  
23 there. Thinking in terms of x-rays, and electro-  
24 cardiographs, those are in the hospital.

25 COMMISSIONER BALTZAN: How do you  
26 hospitalize patients? Do they all go to one  
27 hospital?

28 DR. JEFFREY: Essentially yes. We are a  
29 group that practice chiefly from the Civic. That  
30 is where our teaching and other responsibilities are.





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1 but we have courtesy facilities in the other  
2 hospitals, and we have occasionally patients here.  
3 Needless to say, we try to discourage it. We try  
4 to centralize in one hospital.

5 COMMISSIONER BALTZAN: You spoke of a  
6 panel, and I didn't get the implications. Do these  
7 people sign up with you as patients?

8 DR. JEFFREY: No, I should not have used  
9 that term. I don't know why it came to mind, but  
10 we have our individual practice. Through choice  
11 any patient can come to any one of us, and we retain  
12 them.

13 COMMISSIONER BALTZAN: And there is no  
14 say financial arrangement, like the prepay?

15 DR. JEFFREY: No.

16 COMMISSIONER BALTZAN: You receive them  
17 as any private pediatrician?

18 DR. JEFFREY: That is right.  
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1 COMMISSIONER GIRARD: Dr. Jeffrey, I  
2 would like to start out by saying I agree with you in  
3 not allocating one nurse to one doctor for the reasons  
4 you mentioned. I think the visiting nursing associations  
5 feel that also because the people will get to know this  
6 nurse in relation to that doctor and call her at her  
7 home and that sort of thing. In a practice like yours  
8 I am sure there are a number of functions that are  
9 essentially nursing functions and I was a little worried  
10 about - I don't know whether I heard you right - about  
11 the two registered nurses keeping busy on the 'phone,  
12 answering 'phone calls and making appointments all day  
13 long. Did I get that right?

14 DR. JEFFREY: Yes.

15 COMMISSIONER GIRARD: This seems to me  
16 like rather poor nursing utilization in view of the  
17 fact of the shortage of registered nurses. I think we  
18 we would like to keep registered nurses as much as  
19 possible doing registered nurses' functions.

20 DR. JEFFREY: That is true and we have  
21 considered changing that except it is very difficult.  
22 These nurses unfortunately have to make appointments  
23 but every second or third call is for minor advice.  
24 We have to keep well-equipped individuals to give that  
25 advice and because of that these nurses have to do  
26 everything. If we had someone else that they could  
27 use entirely for making appointments and transferring  
28 calls; they would come in to a switchboard with one  
29 operator to allocate the calls, it would be better  
30 but we are not in a financial position to do that. I





1 suppose a well-trained switchboard operator could  
2 answer calls and channel calls to the various depart-  
3 ments but we have not been able to afford that service  
4 yet.

5 COMMISSIONER GIRARD: Can you afford  
6 paying a registered nurse's salary to answer the 'phone?

7 DR. JEFFREY: Well, they are so impor-  
8 tant for us. We have to have them anyway and we could  
9 not use them for any other purpose because our 'phones  
10 are busy continuously all day long. As I say, a lot  
11 of these calls are advice and a nurse can give it and  
12 it saves the doctors. We have to maintain these two  
13 nurses anyway. We have given this some consideration  
14 because we are disturbed about it but we have not found  
15 a solution to it.

16 COMMISSIONER GIRARD: Thank you, I  
17 am glad to know that you think the way I do about it  
18 and you are giving some consideration to it.

19 COMMISSIONER FIRESTONE: Dr. Jeffrey,  
20 we have been hearing a lot in the last several months  
21 about the patient-doctor relationship; would you say  
22 that as a result of your group practice this patient-  
23 doctor relationship has been affected adversely?

24 DR. JEFFREY: No, definitely not.

25 COMMISSIONER FIRESTONE: You have had  
26 no complaints, from your experience, that the patient  
27 feels that their relations are affected because they  
28 are now in a group practice or clinic rather than a  
29 single doctor?

30 DR. JEFFREY: We have not had that







1       voiced to us.

2                   COMMISSIONER FIRESTONE: You can only  
3       give us your own experience.

4                   DR. JEFFREY: We practise as indivi-  
5       dual doctors in the group so every patient has his own  
6       doctor in the group.

7                   COMMISSIONER FIRESTONE: But you were  
8       also suggesting to us that the advantages that the  
9       patients have working in a clinic is that physicians  
10      go on holidays and when they are sick somebody else  
11      takes over so that over a period of time the patients  
12      get to know the various members of the group and,  
13      therefore, the doctor-patient relationship has not  
14      been affected adversely from your experience as a  
15      result of the group practice?

16                  DR. JEFFREY: No. We will find  
17      occasionally a patient who has a dislike for one of our  
18      group but that is inevitable and that is a calculated  
19      risk that every doctor has to take. When he leaves on  
20      vacation or through illness someone has to cover.

21                  COMMISSIONER FIRESTONE: Except for  
22      the exceptional case, by and large your experience has  
23      been favourable?

24                  DR. JEFFREY: Yes, very favourable.

25                  COMMISSIONER FIRESTONE: My second  
26      question relates to the point that the Chairman raised  
27      earlier about establishing a new group practice and  
28      particularly in rural areas. My question is: how do  
29      people go about that when they have not been in group  
30      practice and they want to establish a group practice?





1 Is there a group or an organization to go to for advice?

2 DR. JEFFREY: I think the Ontario  
3 Medical Association has a committee on group practice  
4 and can probably give you considerable information in  
5 that regard.

6 COMMISSIONER FIRESTONE: In other words,  
7 it would be your view that the provincial association  
8 of the medical profession should have a service which  
9 should provide this information covering not only the  
10 organization of the medical practice itself but also  
11 the auxiliary services which you have outlined to us  
12 which are quite important?

13 DR. JEFFREY: Yes, I would think so.

14 COMMISSIONER FIRESTONE: Would you feel  
15 such a service would be carried on on a continuing  
16 basis and the members of the Medical Association are  
17 the best people to do it?

18 DR. JEFFREY: Yes, I would think there  
19 should be some central source to provide this. We had  
20 to do it without this help.

21 COMMISSIONER FIRESTONE: Are you aware  
22 there is such a central organization in existence  
23 sponsored by the Canadian Medical Association?

24 DR. JEFFREY: I do not know.

25 COMMISSIONER FIRESTONE: We will be  
26 able to get that information directly from the Canadian  
27 Medical Association. Your point is if such a central  
28 organization does not exist it would be a desirable  
29 thing to have such an organization established to assist  
30 other groups or individuals to form partnerships and







1 clinics and group practices?

2 DR. JEFFREY: I would say so, yes.

3 COMMISSIONER FIRESTONE: The third  
4 point: have you had any knowledge whether the group  
5 practices in Canada are increasing or is this a static  
6 thing or is this type of practice becoming more popular  
7 in view of the rather substantial advantages which you  
8 have outlined for us as far as the patient is concerned  
9 and as far as the participating physicians are concerned?

10 DR. JEFFREY: I am not qualified to  
11 speak to this. Actually, we have not joined any associa-  
12 tion of clinics because we consider ourselves more of a  
13 partnership; we do not give the broad medical service  
14 that clinics provide so that we are really a partner-  
15 ship. I am not really familiar with the growth of  
16 actual clinics. I understand these are more common  
17 out west than they are in the east. There is a resis-  
18 tance to it in the large centres because of a clique  
19 formation but I can say as far as our partnership is  
20 concerned there has been no - our standing within the  
21 paediatric profession in the city has not been hurt  
22 by the partnership. We practise ethically and are  
23 accepted by the rest of the paediatricians in the city.

24 COMMISSIONER FIRESTONE: Since you  
25 point out the advantages for both physicians and patients  
26 as a result of what you might describe as a group prac-  
27 tice, is there anything that could be done to encourage  
28 group practice in Canada in the interests of the patient,  
29 in the interests of the physician?

30 You see, this is one of the things







1 that this Commission is concerned with. We are told  
2 group practice is a good thing so what can we do to  
3 encourage something that is good for the health of the  
4 Canadian people?

5 DR. JEFFREY: Well, we feel it is  
6 good. As I have already pointed out, many doctors might  
7 not think this is the best service but I would think  
8 that the ones to negotiate this promotion would be  
9 organized medicine, the Ontario Medical Association at  
10 our level and possibly the Canadian Medical Association.

11 It would have to be reviewed carefully  
12 by them and assessed and if they felt there was any  
13 merit in this I would think it would be up to them to  
14 undertake the promotion of it.

15 THE CHAIRMAN: The original question  
16 here, I think, is, provided that should it be a decision  
17 that group practice was desirable and should be fostered,  
18 have you any thoughts to express as to whether that  
19 should be done on a fee-for-service basis or with the  
20 group contracting with some other group and doing the  
21 work on a capitation basis?

22 DR. JEFFREY: No. Of course, our  
23 set-up demands a fee for service.

24 THE CHAIRMAN: I am not talking about  
25 yours, I am talking about the general principle of a  
26 group practice; does it necessarily depend on being on  
27 a fee-for-service basis or might it prosper, might it  
28 serve the community on a capitation basis?

29 DR. JEFFREY: When you say "capitation  
30 basis", what do you mean?





1 THE CHAIRMAN: Well, say the M.S.I.  
2 or Ontario Medical, as a collector of premiums then  
3 contracting with a group in a certain area to pay for  
4 all the medical services in the area?

5 DR. JEFFREY: You mean for X dollars  
6 they will supply the service?

2 7 THE CHAIRMAN: Yes.

8 DR. JEFFREY: We are a little resistant  
9 to that. This has been tried by individual paediatrici-  
10 cians and I was thinking of doing it. One of my  
11 associates years ago tried it and we felt that the  
12 advantages taken by the public in a situation like that  
13 increases the burden too much on the individual doctor  
14 so we have not considered it again. We know, of course,  
15 it works in industrial medicine, mines in particular,  
16 but we are a little disturbed about it. I think we  
17 prefer - that is why we have set it up - every partner  
18 has equal rights, he collects for what he does and  
19 there is no seniority in our group which is different  
20 to many clinics.

21 COMMISSIONER FIRESTONE: I take it  
22 from what you say you prefer to have a fee-for-service  
23 principle rather than capitation?

24 DR. JEFFREY: We would in our group.

25 COMMISSIONER FIRESTONE: I have one  
26 more question: if there were introduced in Canada a  
27 comprehensive medical care program either on a voluntary  
28 or on a compulsory basis would this affect the group  
29 practice adversely?

30 DR. JEFFREY: Well, our partnership







1 practice it could not because that would apply as much  
2 to a physician practising alone as to physicians practi-  
3 sing within a group. If you relate it to paediatrics  
4 in general, of course, prepaid medical insurance might  
5 have some definite influence but not on any particular  
6 segment of the paediatric group.

7 COMMISSIONER FIRESTONE: Thank you  
8 very much, Doctor.

9 COMMISSIONER VAN WART: Is there any  
10 advantage to a profession owning their own realty  
11 company rather than somebody else owning the realty  
12 company?

13 DR. JEFFREY: Well, we feel there was  
14 a possibility of increasing our equity in something we  
15 might have for future retirement and we had this hope  
16 that we would much rather own our own operation than  
17 lease. We are renting, true enough, one office and we  
18 expect to be doing the same in another but we try as  
19 much as possible to own our own property.

20 THE CHAIRMAN: Thank you very much,  
21 Dr. Jeffrey. It was very kind of you to take the time  
22 out from what we know is a busy practice to be here  
23 with us this morning and you have been most helpful.

24 DR. JEFFREY: It has been a privilege,  
25 I can assure you and I have enjoyed it.

26 THE CHAIRMAN: We will rise now until  
27 2.15.

28  
29 --- Luncheon adjournment.  
30





1 ---On resuming at 2:15 p.m.

2 MR. HALL: Mr. Chairman the next submission  
3 is that of the Canadian Federation of Agriculture.  
4 I would ask that the brief which they have filed be  
5 submitted as Exhibit No. 190.

6 ---Exhibit No. 190: Brief of the Canadian  
7 Federation of Agriculture.

8 Appearances: Dr. H.H. Hannan  
9 Dr. W.C. Hopper  
10 Mr. D. Kirk

11 MR. HALL: Dr. Hannan would you please at  
12 the outset describe for the Commission the Canadian  
13 Federation of Agriculture and tell us how it is  
14 composed? What the membership consists of?

15 DR. HANNAN: Mr. Chairman and members of  
16 the Commission the Canadian Federation of Agriculture  
17 is a national general farm organization. Its  
18 structure is a federated one, designed to provide  
19 a means through which bona fide farmer organizations  
20 of all kinds may give unified expression to their  
21 views on matters of public policy. This objective  
22 of comprehensive representation is to a very  
23 considerable extent achieved in the C.F.A. The  
24 Federation is fully national, with the exception of  
25 Newfoundland. Its membership embraces farmer  
26 organizations of all kinds: direct membership  
27 organizations; farmer cooperative; commodity  
28 associations; marketing boards; agricultural societies,  
29 farm women's organizations. The National Farm  
30 Radio Forum is our adult radio program and has been  
for twenty-two years. I mention that only because







1 we have had topics on it almost every year in respect  
2 to health.

3 5. The members of the CFA consist of  
4 provincial Federations of Agriculture in all four  
5 western provinces, Prince Edward Island and Ontario;  
6 three major farm organizations in Quebec; not an  
7 official Federation of Agriculture; not a formal  
8 one there, a Maritime Federation of Agriculture; and  
9 three national or regional organizations, namely,  
10 Dairy Farmers of Canada, the United Grain Growers,  
11 which functions in four western provinces, and the  
12 Canadian Horticultural Council, which is national  
13 for fruits and vegetables. The provincial federations  
14 themselves vary in structure. Without attempting  
15 fully to describe them we are attaching to this  
16 submission, for the information of the Commission, a  
17 complete listing of our members and of their  
18 constituent organizations, as found in Appendix A.  
19 The nature of the organization makes it impossible to  
20 give a precise figure on the number of farmers  
21 represented through the Canadian Federation of  
22 Agriculture, but we can confidently say that at least  
23 three quarters of Canada's farmers find association,  
24 one way or another, through the organizations that  
25 make up the CFA.

26 MR. HALL: Doctor would you tell us what  
27 part, if any, your member organizations played in the  
28 formulation of the policies and recommendations which  
29 are set out in your submission?

30 DR. HANNAN: We have an annual meeting each







1 year and our overall national policies are decided  
2 there, but practically all of the business of that  
3 meeting consists of resolutions that come from the  
4 farm communities in all provinces, coming up through  
5 the provinces. Then we have an eastern conference  
6 for the eastern provinces and a western conference  
7 for the western provinces. The ones that pass both  
8 of those then come to the National Organization  
9 but health is a question that is practically always  
10 on the agenda of our provincial and national  
11 organization. It's a perennial that comes up  
12 practically every year. Then we had a complete  
13 program in 1943, as far back as 1943 which we  
14 presented to an Advisory Committee on Health in  
15 Ottawa and it was very much along the same line  
16 as this one.

17 MR. HALL: At your annual meeting this year  
18 I believe there was a resolution introduced regarding  
19 health generally?

20 DR. HANNAN: Yes. Actually there were two.  
21 One was the resolution and then there were  
22 seven clauses as well that set up the framework for  
23 our presentation.

24 At the 26th Annual Meeting of the  
25 Canadian Federation of Agriculture, held in Banff  
26 in January of this year, the following resolution  
27 was adopted:

28 RESOLVED that the Canadian Federation  
29 of Agriculture support measures to  
30 obtain a complete prepaid National





1 Health Insurance Plan under  
2 provincial and Federal Government  
3 sponsorship and control, to give  
4 full medical and surgical care at  
5 a premium that the lowest income  
6 group can reasonably afford.

7 2. This resolution contains the central  
8 recommendation of the Federation to this Commission.  
9 Its position was further developed and elaborated by  
10 the annual meeting by the adoption of the following  
11 seven principles of policy. This is another resolution.  
12 These seven principles constitute our basic policy  
13 mandate from our membership in appearing before this  
14 Commission.

15 (a) That the particular circumstances  
16 of long distances and scattered population  
17 of farm and rural communities be fully  
18 taken into account in the improvement  
19 of the organization of health services.

20 (b) That the Federal Government  
21 adopt as a policy the implementation  
22 of a national compulsory medical  
23 care insurance program to be carried  
24 out in cooperation with the provinces.

25 (c) That public medical insurance be  
26 implemented on a basis that is  
27 contributory to a reasonable degree,  
28 rather than fully supported from  
29 general revenue, but that the basis  
30 of contributions be such that no







1 unreasonable burden is imposed on any  
2 family or persons.

3 (d) That in any insurance plan  
4 the principle of the right of  
5 the patient to choose his own doctor  
6 be retained.

7 (e) That in any health insurance  
8 plan which may be implemented, the  
9 terms and conditions of such plans  
10 be so designed as to permit the  
11 development, wherever consumers  
12 wish to take action, of cooperative  
13 joint provision of medical services  
14 such as group practice, cooperatively  
15 owned and operated clinics, and like  
16 endeavours.

17 (f) That the Commission give  
18 particular attention to, and recommend  
19 ways of achieving, the coordinated  
20 planning of all services and  
21 conditions related to health --  
22 preventative, curative, nutritional  
23 and social -- so that as far as  
24 possible the physical and mental  
25 health of the people shall be  
26 preserved, protected and improved  
27 on all fronts.

28 (g) That the principles be accepted,  
29 and means of implementing it  
30 recommended, that the provision





1 of psychiatric services should  
2 be essentially provided by means  
3 of public services, rather than  
4 through private practice.

5 MR. HALL: Can you develop then your  
6 recommendations and submissions in view of those  
7 general principles which the Membership has laid  
8 down, doctor?

9 DR. HANNAN: Since our brief is not too  
10 long, I think perhaps it will be best for me to  
11 read it. I am sure it will make a better presentation  
12 if I do.

13 3. This submission will not be a long one.  
14 Our purpose is essentially to place before you the  
15 fundamental views and social philosophy of our  
16 membership. We have not had the opportunity of  
17 undertaking independent research or survey work in  
18 connection with the position as regards the provision  
19 of health services to farm people. Any statistical  
20 or documentary evidence used in this submission will  
21 be for the purpose of illustrating the nature of  
22 ~~and sources for the information concerning the health of~~  
23 will be used sparingly because it will be from sources  
24 that are readily available and probably already  
25 familiar to the Commission.

26 4. We think this submission, brief though it  
27 will be, is one to which the Commission should attach  
28 considerable importance. Its importance lies in the  
29 fact that it is a valid expression of the predominant  
30 thinking of farm people in Canada -- a large and





1 significant section of the general population.

2 6. Concern about the need for health  
3 insurance dates back a good many years in The  
4 Canadian Federation of Agriculture. In 1943 The  
5 Canadian Federation of Agriculture published a booklet  
6 called "Health on the March" in which it set out  
7 proposals for a very comprehensive National Health  
8 Insurance Plan for Canada. Attached as Appendix B  
9 to this brief is the statement of principles submitted  
10 to the Advisory Committee on Medical Care in 1942  
11 and on which the booklet is based. We place this  
12 document before the Commission because essentially  
13 the views of the Federation have not changed, and  
14 it illustrates the long-continued concern of the  
15 Federation in this matter. In the intervening years  
16 numerous resolutions have been passed to the same  
17 general effect.

18 7. There have been modifications in Federation  
19 thinking, of course. Notably, it does not today  
20 seem to our members that the best course, at the  
21 moment at least, is to think in terms of a purely  
22 Federal plan, financed entirely from the Consolidated  
23 Revenue Fund of Canada, as was recommended at that  
24 time. The principles of equity to every Canadian  
25 citizen, and security of adequate service, that led  
26 the CFA to this view in the early forties should  
27 still be guiding principles of public policy.  
28 However, regard to the constitutional division of  
29 authority, recognition of the trend of public policy  
30 since that time, as in hospital insurance, and







1 awareness of the advantages and flexibility in many  
2 respects of provincial control, have led to a modification  
3 of view.

4 8. In addition, it seems desirable at this time,  
5 in view of the rising level of incomes since the war,  
6 to make the plan contributory in part.

7 9. The basic concept that it is a right of  
8 every citizen to have the best in medical care, and  
9 not to be deprived of it, or placed in financial  
10 jeopardy, because of lack of financial means, remains  
11 unchanged. The concept that the protection of health,  
12 and prevention and cure of illness, and rehabilitation  
13 should be approached on a planned, co-ordinated, and  
14 comprehensive basis remains also.

15 Planning and Co-ordination of Health Services.

16 10. We would draw the Commission's attention to  
17 point 6 in the statement of principles set out at the  
18 beginning of this submission. It reads:

19 "That the Commission give particular  
20 attention to, and recommend ways of  
21 achieving, the co-ordinated planning  
22 of all services and conditions  
23 related to health - preventative,  
24 curative, nutritional and social -  
25 so that as far as possible the  
26 physical and mental health of the  
27 people shall be preserved, protected  
28 and improved on all fronts."

29 11. This statement expresses a broad concern  
30 on the part of The Canadian Federation of Agriculture





1 to which we wish to draw your particular attention.

2 It encompasses an area that is too broad to permit  
3 of detailed implementing recommendations from the  
4 Federation. We would quickly grant our lack of  
5 competence to make such detailed recommendations.

6 12. We think the significance of this  
7 recommendation for the Commission is, however, clear.  
8 It is this: Farm people would, we believe, be deeply  
9 disappointed if the Commission did not seize the  
10 opportunity that this enquiry gives it of charting  
11 the basis for the planned development of complete and  
12 fully integrated health services in Canada. No doubt  
13 there will need to be priorities set, and an evolution  
14 (over not too long a period, one would hope) toward  
15 some of the objectives set.

16 13. The Canadian Federation of Agriculture would  
17 subscribe wholeheartedly to the principles set out  
18 in the preamble to the Constitution of the World  
19 Health Organization, namely:

20 "Health is a state of complete  
21 physical, mental and social well-  
22 being and not merely the absence  
23 of disease or infirmity.

24 "The enjoyment of the highest  
25 attainable standard of health  
26 is one of the fundamental rights  
27 of every human being without  
28 distinction of race, religion,  
29 political belief, economic or  
30 social condition.







1 "Governments have a responsibility  
2 for the health of their peoples  
3 which can be fulfilled only by the  
4 provision of adequate health and  
5 social measures."

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14. These words will be quoted to the Commission many times, we know. But we think they bear repeating because they provide the best possible starting point and guiding philosophy for the Commission.

15. In this connection we are impressed with the emphasis for planned and comprehensive co-ordination of health services in a total program that one obtains from such authorities as the Canadian Public Health Association and the School of Hygiene of the University of Toronto (in their statements to the preliminary hearings of this Commission), and the Saskatchewan Continuing Committee of the Regional Boards of Health (to the Saskatchewan Advisory Planning Committee on Medical Care).

16. One more point on this general question. In line with the Canadian Federation of Agriculture's basic belief in the desirability and utility of broad democratic participation by the citizen in the determination of his own affairs, we would recommend that, in considering all questions of public provision, planning, and insuring of health services, the need for citizen education and participation be constantly kept in mind. Such participation is, we believe, absolutely necessary. It is of equal importance to ensure that the knowledge, competence, and authority of doctors and other professional personnel are fully utilized and respected.

#### The Position of Farm and Rural People

17. There is not a lot of information specifically on the absolute and relative position of farm and rural





1 people with respect to the adequacy of the health  
2 services they receive. At least we have not  
3 encountered such information in the course of our  
4 enquiries. There has, in rural areas, been a  
5 considerable development of voluntary medical  
6 insurance coverage, and a significant development  
7 of voluntary medical insurance coverage, and a  
8 significant development, in Saskatchewan particularly,  
9 of municipal doctor schemes. Nevertheless, such  
10 evidence as there is would indicate that rural people  
11 do not enjoy as full a coverage of voluntary medical  
12 insurance, and have a greater incidence of sickness,  
13 a lower level of provision of medical services than is  
14 true of urban areas.

15 18. The Canadian Sickness Survey, 1950-51, does  
16 give some breakdowns on the basis of a metropolitan  
17 and non-metropolitan division. These show the position  
18 to be relatively less satisfactory in non-metropolitan  
19 areas. It can be safely assumed, one would think,  
20 that farm people would be at least as disadvantaged  
21 as the non-metropolitan group as a whole, and very  
22 likely more so in view of their greater isolation from  
23 population centres.

24 19. The Survey shows that:

25 (a) Sickness both with and without  
26 disability was higher in non-  
27 metropolitan than in metropolitan  
28 areas (See Chart 13, page 31);

29 (b) Doctors' calls and clinic visits  
30 per 1,000 of the population were lower







1 for non-metropolitan (at 1,579) than  
2 for metropolitan areas (at 2,062).  
3 (See table page 31).

4 20. A brief, interesting insight into the medical  
5 care situation in at least one rural community is found  
6 in a paper "Medical Care in Wheatville" by Robin F.  
7 Badgley, Ph.D., and Robert W. Metherington, B.A.  
8 This paper, presented to the Canadian Public Health  
9 Association in June of 1961 records some results of  
10 a survey of doctors and public health nurse records  
11 in an unidentified Saskatchewan community in 1959 and  
12 1960.

13 21. In this community only 12.4 per cent of  
14 the physicians' patients had voluntary medical insurance  
15 coverage. Public programs covered the expenses  
16 of another 4.4 per cent of the patients. The rest -  
17 83.2 per cent - had no medical coverage. For the  
18 province as a whole the medical insurance coverage is  
19 about 67 per cent. "Wheatville" is therefore not  
20 altogether typical. The figures do lend support,  
21 how ver, to the notion that coverage in farm and rural  
22 areas is very significantly below the average.

23 22. Actually, allowing for the full coverage  
24 of the Swift Current Region in Saskatchewan and the  
25 municipal doctors' schemes, it seems likely that  
26 the situation in "Wheatville" would be found not very  
27 atypical of rural areas after all. Certainly, in the  
28 absence of adequate data on this point, one may very  
29 reasonably assume that voluntary insurance coverage  
30 for farm and rural people is really quite low, perhaps





1 ranging from 15 to 30 per cent. The national coverage  
2 as given by the 1958 survey of voluntary medical  
3 insurance of the Department of National Health and  
4 Welfare shows 43.2 per cent coverage of the total  
5 population on an unduplicated basis.

6 23. The doctors in this community estimated that  
7 with universal medical care coverage in the community  
8 their gross incomes would rise 50 per cent -- through  
9 greater numbers of patients, collection of the 20 per  
10 cent of bills now unpaid, and the charging of fees  
11 at the full recommended rates where this is not now  
12 done. In other words, some persons are not getting  
13 needed medical care now in this community, and many  
14 others are being treated on the charity of the doctor  
15 or at the expense of the paying patients, however one  
16 looks at it. This is an unsatisfactory situation all  
17 round and should be corrected by universal medical  
18 coverage under a public health insurance program.

19 24. The need for co-ordination of services is also  
20 demonstrated in the study by the fact that only about  
21 one person in four under twenty years of age who was  
22 reported by the public health nurse to have a health  
23 problem actually visited the doctor.

24 25. Another way of attempting some statistical  
25 insight into the farm and rural position is to  
26 contrast the correlation between incomes and adequacy  
27 of medical care as demonstrated by the Sickness Survey,  
28 with the income position of the farmer.

29 26. First, the farm income position. This is  
30 an admittedly somewhat difficult statistical area.







1 However, we think a very meaningful comparison may  
2 be made on the basis of labour force figures showing  
3 employment in agriculture, on the one hand, and national  
4 income statistics showing personal income on the  
5 other. It should be noted that the labour force  
6 figures for farmers are for self-employed and unpaid  
7 family workers. This is a statistical calculation of  
8 persons actually working at the job on the survey dates.  
9 We are not, that is to say, taking a census figure of  
10 a number of farmers, regardless of whether they are  
11 also employed in agriculture full time or not. Such  
12 a figure would be much higher than the figure for  
13 self-employed on farms in the labour force. Neither,  
14 on the other side, are we including persons out of work.  
15 The picture shapes up like this:

16 Labour Force

17 Average total employed labour force,  
18 1960 - 5,955,000  
19 Average total farm labour force,  
20 1960 (excluding paid workers) 565,000  
21 Per cent farm of total labour  
22 force 9.5 per cent

23 Source: The Labour Force - DBS

24 Income

25 Accrued Net Farm Income of Farm  
26 Operators, 1960 \$ 1,207 million  
27 Total Personal Income, all  
28 persons, 1960 23,191 million  
29 Per cent accrued net farm  
30 income of total personal income 5.2 per cent\*





1 Source: National Accounts, Income and Expenditure -DBS  
2 (\*That is 5.2 per cent as compared to the 9.5 in  
3 numbers).

4 27. With the 9.5 per cent of the labour force  
5 which is on the farm earning only 5.2 per cent of  
6 the personal income, it is perfectly clear that, to  
7 say the least, farmers are a significantly  
8 disadvantaged group, economically, taking them as a  
9 whole. We do not want to make too much of these  
10 figures. In the first place, as in other occupations,  
11 there is a wide range of incomes, and the important  
12 point is, of course, that low-income families, in  
13 farm or city, need universal medical insurance of  
14 the kind we are advocating. In the second place, they  
15 are an examination of the returns to farming compared  
16 with the returns to the total working force. They  
17 are not, precisely, an examination of the returns to  
18 farm and certainly not to rural families from  
19 whatever economic source.

20 28. Nevertheless, these figures do show that  
21 as an occupational class farmers might be expected to  
22 be particularly interested in the problem of the  
23 extension of health services on the basis of  
24 their income status, on the assumption that low-  
25 income people are particularly disadvantaged in this  
26 respect. That they are so disadvantaged is shown by  
27 the following tables from the Canadian Sickness  
28 Survey, 1950-51:  
29  
30





Physicians' Calls and Clinic Visits (Standardized)

Income Group	Per 1,000 population	Per 1,000 persons reporting calls and/or visits
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Low income	1,468	3,717
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Medium income	1,810	4,014
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High income (lower)	1,852	4,151
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High income (upper)	2,172	4,375
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Physicians' Calls and Clinic Visits  
per 100 Disability Days (standardized)

Low income	8.5
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Medium income	16.4
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High income (lower)	19.2
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High income (upper)	19.1
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Persons Reporting Hospital Care  
per 1,000 Population by Income

Low income	102
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Medium Income	112
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Average Expenditure on Health Care per Spending Family  
by Family Size and Income

	1 person	2 persons	3-4 persons dollars	5-6 persons	7 or more
Low	43.60	70.30	74.90	68.60	60.00
Medium	55.60	95.10	104.80	102.50	116.60
High (lower)	98.20	101.00	128.50	145.00	101.40
High (upper)	--	146.50	169.10	171.60	--

Average Expenditure on Prepayment Plans

Income Group	Reporting Rate %	Average Expenditure \$
Low	28.8	24.90
Medium	55.2	40.00
High (lower)	67.0	48.70
High (upper)	64.4	57.00







Percentage of Spending Families for Extremes of  
Expenditure

Expenditure Group	Low income	High (upper) per cent
\$1 - 19	41.2	4.4
\$100 and over	1.3	8.8

29. In short, the low-income groups had more sickness and disability, lower expenditure on health care, less prepayment coverage and lower expenditure where prepayment was carried, than higher income groups. For farm families must be added the costs of being at a distance from doctors, and especially specialists, and the lower availability of group plans.

Voluntary versus Universal Coverage

30. The Canadian Federation of Agriculture is, of course, aware that there is basic opposition in the medical profession to universal health insurance under government plan. The preliminary submission to you of the Canadian Medical Association is not clear on this point but subsequent submissions by provincial associations have been. We gather that much of the medical profession views with favour, instead of universal coverage under state auspices, the progressive development of voluntary insurance plans, enlarged, co-ordinated, and supplemented by government payment of premiums under these or special plans for indigents and others judged unable to pay as determined by means test. In their view, it seems, universal coverage might be substantially achieved in this way.

31. It seems to the Canadian Federation of





1 Agriculture that the essential difference in these  
2 two concepts which forms the source of the controversy  
3 (this is apart from the vital questions of whether  
4 the voluntary approach would, in fact, achieve adequate  
5 coverage and other issues of the kind) is this: the  
6 voluntary plan approach, however elaborated or  
7 supplemented, leaves very much in the hands of the  
8 medical profession the questions of administration of  
9 most of the plans, of rates of remuneration, of control  
10 of misuse, of organization of medical services, of  
11 co-ordination with public health services, and so on.  
12 The governmental approach, even on a fee-for-service  
13 basis, does open up an avenue of review by government,  
14 and/or by Commission, of some of these things, and  
15 a continuing interest and responsibility of government  
16 in others -- all in the interests of the effectiveness  
17 and reasonable economy of the services given, and  
18 on behalf of the consumer.

19 32. On this controversial question we may  
20 confidential say, on behalf of our members, that they  
21 do not see what is wrong with the injection into this  
22 great and vital area of service -- that is, medical  
23 care --an element of public responsibility not only  
24 for ensuring universal coverage, but for how the  
25 job is done and how much is paid to have it done.

26 33. In both the voluntary plan and the  
27 government plan approaches a heavy institutionalization  
28 and systematization of health services is involved --  
29 and the development of what would virutally be a great  
30 public utility. The differences are that in one case --







1 the voluntary scheme approach -- there is no assurance  
2 that the job will be done fully and adequately and  
3 equitably from the point of view of coverage and  
4 incidence of cost. In addition, the medical profession  
5 is essentially left with exclusive jurisdiction  
6 and control. In the other case full and adequate  
7 coverage of the need can be assumed, and the public  
8 is given a reasonably authoritative role in saying what  
9 it shall pay to do the job and, in some limited but  
10 important respects perhaps, how it shall be done.

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1                                   34. The view that involvement of the  
2 state to this degree is destructive of the freedom of  
3 the medical profession, and an ultimate threat to its  
4 professional integrity, seems to us to be really a  
5 cynical one. It assumes a degree of irresponsibility  
6 on the part of the public, and a crassness of motivation  
7 on the part of the medical profession, that does not  
8 seem to our people to be acceptable. In any case it is  
9 a view that The Canadian Federation of Agriculture does  
10 not share. We would not for a moment deny or underrate  
11 the great importance of maintaining, in the medical  
12 profession, very high standards of integrity, profes-  
13 sional competence, and ideals of public service. Nor  
14 would we deny the need to pay our doctors very adequately.  
15 We would not deny that the practice of medicine must be  
16 left to medical people. We do not see how or why univer-  
17 sal medical insurance, governmentally established and  
18 administered, should destroy these things. Rather, it  
19 should provide the economic basis upon which to build  
20 new and improved standards of service and responsibility.

21                               35. In 1958, according to the publica-  
22 tion "Voluntary Medical Insurance in Canada", only 43.2%  
23 of the population of Canada was covered by voluntary  
24 prepayment plans. The Sickness Survey figures make it  
25 clear that, of the remainder, the heaviest proportion  
26 will be in the lower income groups, with farm and rural  
27 people heavily represented. The coverage that exists  
28 for those covered varies greatly. Many people are  
29 excluded from voluntary plans, for economic reasons,  
30 and for reasons of chronic illness and disability.







1 Any idea that all these problems can be taken care of  
2 properly, fairly and with dignity to the individual by  
3 vast adoption of special subsidization of voluntary  
4 plans, and by means tests - or that the problem will  
5 take care of itself in any reasonable time without  
6 such strategems - strikes us as unreasonable.

7 36. The fundamental consideration is  
8 that we think we should have now arrived in this country  
9 at the point where adequate health services should be  
10 considered a right of every citizen and a responsibility  
11 of the nation. We think this is sufficiently important  
12 and fundamental, both for the individual and in the  
13 public interest, that the economic position of the indi-  
14 vidual should not significantly affect his ability to  
15 obtain these services, nor should the cost of such  
16 services be an unreasonable burden on anyone. We are a  
17 long way yet from achieving this objective. Universal  
18 medical care insurance, financed by moderate premiums  
19 supplemented by Federal and provincial government tax  
20 revenue, can be and should be a very big step in this  
21 direction. Achievement of this involves redistribution  
22 of income, as between individuals, between areas, and  
23 between provinces.

24 Review of Basic Policy

25 37. We would now like, very briefly,  
26 to run over the seven points in the statement of prin-  
27 ciples of the Federation set out at the beginning of  
28 this submission:

29 (a) "That the particular circumstances  
30 of long distances and scattered







1 population of farm and rural communi-  
2 ties be fully taken into account in  
3 the improvement of the organization of  
4 health services". We do not have many  
5 detailed recommendations in this connec-  
6 tion. The concern we feel, however, is  
7 first, that hospital and specialist as  
8 well as general practitioner service  
9 should be so organized on a local,  
10 regional and provincial basis that the  
11 best possible provision of medical and  
12 hospital care is assured. We would ask  
13 the Commission to satisfy itself, for  
14 example, on the need for the develop-  
15 ment, staffing and servicing of clinics  
16 and group practice arrangements; on the  
17 need for the better organization of  
18 laboratory and other services; on  
19 problems and requirements with respect  
20 to public health services in rural areas;  
21 on rehabilitation needs. In each case  
22 we would ask that practicable means of  
23 meeting these needs be recommended.  
24 Serious consideration should be given  
25 to the possibility that in the interests  
26 of equity special provision should be  
27 made for meeting transportation costs  
28 for farmers and other persons who incur  
29 unusual expense in this connection as  
30 a result of their physical isolation.





1 (b) "That the Federal Government adopt  
2 as a policy the implementation of a  
3 national compulsory medical care insu-  
4 rance program to be carried out in  
5 co-operation with the provinces". We  
6 have not much to add on this point to  
7 what we have already said. We do know  
8 our members would wish the coverage in  
9 such a program to be comprehensive,  
10 excluding only optical and dental  
11 services, and perhaps drugs. On the  
12 question of drugs, the best answer is  
13 probably an arrangement whereby persons  
14 whose medical problem requires protract-  
15 ed use of drugs at a burdensome cost  
16 should have these costs met by the  
17 insurance.

18 (c) "That public medical insurance be  
19 implemented on a basis that is contri-  
20 butory to a reasonable degree, rather  
21 than fully supported from general reve-  
22 nue, but that the basis of contributions  
23 be such that no unreasonable burden is  
24 imposed on any family or persons".

25 The intent here is that premiums  
26 should not be paid at all by indigents,  
27 and that the general level of premiums  
28 payable should be uniform for all  
29 income classes outside of indigents,  
30 and low enough not to be a burden on







1 the lowest income group. This recom-  
2 mendation obviously assumes very substan-  
3 tial financing from general tax revenue.

4 (d) "That in any insurance plan the  
5 principle of the right of the patient  
6 to choose his own doctor be retained".  
7 We think this is a clear-cut statement  
8 of principle.

9 (e) "That in any health insurance plan  
10 which may be implemented, the terms  
11 and conditions of such plans be so  
12 designed as to permit the development,  
13 wherever consumers wish to take action,  
14 of co-operative joint provision of  
15 medical services such as group practice,  
16 co-operatively owned and operated  
17 clinics, and like endeavours". To make  
18 sure our meaning is clear here we would  
19 first explain that this recommendation  
20 is not intended to recommend any form  
21 of insurance or group payment for  
22 services outside the universal plan we  
23 are advocating. What we are concerned  
24 to ensure is that where groups of citi-  
25 zens, as consumers of medical services,  
26 wish to employ doctors and set up their  
27 own provision for group practice or  
28 clinics, that insurance benefits might  
29 be paid to such co-operatives. It is  
30 conceivable a plan might be drawn which





1 excluded the possibility of such  
2 arrangements by accident or design.

3 In this recommendation we are supporting  
4 the policy of the Co-operative Union  
5 of Canada.

6 (f) "That the Commission give particular  
7 attention to, and recommend ways of  
8 achieving, the co-ordinated planning of  
9 all services and conditions related to  
10 health - preventative, curative, nutri-  
11 tional and social - so that as far as  
12 possible the physical and mental health  
13 of the people shall be preserved,  
14 protected and improved on all fronts".

15 We have already discussed this recommen-  
16 dation.

17 (g) "That the principle be accepted,  
18 and means of implementing it recommended,  
19 that the provision of psychiatric  
20 services should be essentially provided  
21 by means of public services, rather  
22 than through private practice". It is  
23 our thinking in this connection, that  
24 as rapidly as possible adequate psychia-  
25 tric services should be made available  
26 to all the population, through psychia-  
27 trists and psychologists employed by  
28 child welfare clinics, public clinics,  
29 hospitals and other appropriate agencies.  
30 We do not exclude this service from the





1 general principle that it should be  
2 available to all. We do not think,  
3 however, that in this case it would be  
4 desirable to think of the field of  
5 psychiatric services as being, for the  
6 most part, one that should be met  
7 through private practice. Consequently,  
8 we would not recommend its inclusion in  
9 insurance coverage on the same basis as  
10 medical services. The difficulties of  
11 insuring for such a service would be  
12 very great, and in our opinion it is  
13 unnecessary for the problem to arise.  
14 And then we just have a mention of drugs.

15 Drugs

16 38. The cost of drugs is a matter of  
17 vital concern in connection with health services and we  
18 recommend that the Commission interest itself in this  
19 question. Attached as Appendix C is a copy of the  
20 submission of The Canadian Federation of Agriculture to  
21 the Restrictive Trade Practices Commission investigating  
22 the manufacture, distribution and sale of drugs. In  
23 this submission we state:

24 "A reading of the study of the Director  
25 of Investigation and Research (of the  
26 Combines Investigation Branch) makes  
27 it impossible to arrive at any other  
28 conclusion than that in fact the  
29 consumer is being vastly overcharged  
30 for most of the ethical drugs which he







1 purchases".

2 39. The submission also contains  
3 certain recommendations which we think would contribute  
4 to meeting the problem.

5 Thank you.

6 THE CHAIRMAN: Thank you very much,  
7 Dr. Hannan.

8 MR. HALL: Mr. Chairman, Dr. Hannan  
9 is prepared to answer any questions which the Commission  
10 may have arising out of the submission.

11 THE CHAIRMAN: Dr. Hannan, if I may  
12 deal with one subject here, actually it is this last  
13 one on principle, on page 13, (g), dealing with psychia-  
14 tric services. It has been told to us at various times  
15 in our hearings that the proportion of mental illness in  
16 Canada is high, and that, not giving these figures as  
17 accurate figures, but as just figures, that one out of  
18 every two patients in a hospital bed in Canada today is  
19 a mental patient, so that just the mere saying that indi-  
20 cates, whether that may not be, it won't be correct as a  
21 matter of arithmetic, but somewhere between 40 and 45%  
22 as perhaps a more correct figure.

23 Now, if that should be the case, and  
24 if you accept that, would that change your view that  
25 insuring against the need for psychiatric services  
26 should be excluded, when you would appear to be excluding  
27 some 40 to 45% of ill people, regarding mental illness  
28 in the same category as physical illness?

29 DR. HANNAN: Well, Mr. Chairman, no,  
30 we don't wish to do that. We were rather of the opinion





1 that psychiatric services is a specialized problem.  
2 It was somewhat difficult for us to deal with. We  
3 believe that it would also be very difficult to administer  
4 in the early stages of a plan, and therefore we just  
5 felt that we didn't like to include it as complete  
6 coverage in the overall plan, but that it should be  
7 given very special care in clinics, in hospitals, in  
8 appropriate agencies, so that it was not dependent upon  
9 private service.

10 THE CHAIRMAN: Well, I was just accep-  
11 ting, without getting into an argument. You say, at  
12 the foot of page 13:

13 "We do not think, however, that in  
14 this case it would be desirable to  
15 think of the field of psychiatric  
16 services as being, for the most part,  
17 one that should be met through private  
18 practice".

19 That is, you are contemplating that it  
20 will be dealt with on a governmental basis, or at least  
21 on some public authority basis?

22 DR. HANNAN: That is right. I think  
23 I might say, Mr. Chairman, that if it were to be included  
24 in a national health insurance plan, or if it were  
25 desirable to include it, we would not oppose that.

26 THE CHAIRMAN: The discussion arises  
27 in two ways, as you will appreciate now, that in the  
28 present Hospitalization and Diagnostic Services Act,  
29 mental illness is excluded in the items, in the area  
30 where there is a shared cost between the Dominion and







1 the provincial governments. Now, it has been suggested  
2 to us all across Canada that that discrimination, as it  
3 is put, should disappear. We should recommend that  
4 mental illness be dealt with on the same footing as  
5 physical illness, in terms of shared operative costs.

6 DR. HANNAN: With your approval, may I  
7 have my associates take part?

8 THE CHAIRMAN: Yes. Mr. Kirk?

9 MR. KIRK: Yes sir, I hope we haven't  
10 misrepresented our position here.

11 THE CHAIRMAN: It is that you would  
12 have now the opportunity to state it clearly.

13 MR. KIRK: The intent of this is princi-  
14 pally as you point out that we do not think that the  
15 fee-for-service principle, that you just insure people,  
16 you say that they may have psychiatric services in the  
17 same way as if they become ill that you go to a doctor  
18 in this regular fashion is feasible.

19 Our thinking is most certainly that to  
20 the maximum extent that the personnel is available that  
21 these services should be available to everyone who needs  
22 them. That certainly is the intent that we have them.  
23 It was the inclusion in the regular way in the insurance  
24 program that we were suggesting was not feasible.





1 THE CHAIRMAN: You mentioned on at least  
2 two occasions in your brief and perhaps more but  
3 certainly on two occasions this matter of what would  
4 have to be some priorities in the organization of  
5 health services. Now, if you accepted these figures  
6 I give you as a basis we are spending, say, on an  
7 average of \$25.00 or more per patient in the caring  
8 of physical illness, that is per day, as against  
9 \$5.00 a day in round figures on the mentally ill.  
10 Would an acceptance of those figures cause any  
11 change in your thinking in terms of priorities as  
12 to what group of citizens are entitled to the  
13 first consideration in the development of a new  
14 plan; the physically ill who are already covered by  
15 the Hospital and Diagnostic Services Act and so  
16 forth and for whom approximately \$20.00 a day is being  
17 expended or the mentally ill in these large mental  
18 hospitals and so forth on whom approximately \$5.00  
19 a day was being spent.

20 DR. HANNAN: My personal opinion is that  
21 our health measures have not progressed as far for  
22 the mentally ill as for the physically ill and,  
23 therefore, we would be in favour of some priority  
24 for the mentally ill.

25 THE CHAIRMAN: Sort of bringing up the  
26 balance, bringing it more into balance?

27 DR. HANNAN: That is right.

28 THE CHAIRMAN: And you leave it to those  
29 on whom the administration would fall to work out the  
30 details?





1 DR. HANNAN: Yes.

2 THE CHAIRMAN: Now, in connection with the  
3 suggestion that you have in paragraph 3 on page 12  
4 where you say:

5 "The intent here is that  
6 premiums should not be paid at all  
7 by indigents, and that the general  
8 level of premiums payable should be  
9 uniform for all income classes outside  
10 of indigents, and low enough not to  
11 be a burden on the lowest income  
12 group."

13 Now, initially would you have in mind  
14 any suggested figure for what would be a uniform  
15 premium but low enough not to be a burden on the  
16 lowest income group?

17 DR. HANNAN: No, we had not considered a  
18 figure. I think we have not had any discussion on  
19 what the figure might be.

20 THE CHAIRMAN: Is it any help to you to  
21 relate that to the \$48.00 that the Province of  
22 Saskatchewan collects for hospitalization as a uniform  
23 fee to which there is contribution from the treasury  
24 so as to lower the fee that might otherwise have to  
25 be charged if the users were to pay the entire cost  
26 of hospitalization?

27 DR. HANNAN: My own thought, and I think it  
28 is one our organization would back, is that would  
29 be higher than we are thinking of.

30 THE CHAIRMAN: Would you still believe that







1 there should be a premium?

2 DR. HANNAN: Yes, we believe it should be  
3 contributory to some degree.

4 THE CHAIRMAN: Are you in a position to make  
5 a suggestion as to where that would start in the  
6 economic scale?

7 DR. HANNAN: You mean with the incomes?

8 THE CHAIRMAN: Yes, by whatever form the  
9 various areas would be identified. You talk about  
10 the indigents, I presume by that you mean those who  
11 are now on social aid of some form?

12 DR. HANNAN: Yes.

13 THE CHAIRMAN: Who have been accepted as  
14 being unable to support themselves. That class, I  
15 suppose, is easy to identify?

16 DR. HANNAN: Our thought would be that  
17 the rest of the citizens would be on a small premium.

18 THE CHAIRMAN: The word "small" is a relative  
19 word. I do not want to press it to the point where  
20 it is knocking your thinking.

21 DR. HANNAN: I thought your question was  
22 in respect to where it would start, that is who pays.

23 THE CHAIRMAN: That is one and naturally  
24 that takes us to the second one, how much?

25 DR. HANNAN: Yes.

26 THE CHAIRMAN: In line with your view it  
27 should be low enough not to be a burden on the lowest  
28 income group I am putting the question on the context  
29 of your statement.

30 DR. HANNAN: It is clearly an opinion of my





1 own and it is has not been discussed by my  
2 organization but I would be inclined to think there  
3 is something to be said for a very small premium paid  
4 annually, perhaps only about half what we would  
5 think it should be. Then, a very small fee should  
6 be charged each person for office call or per week  
7 in hospital on the basis that each person that  
8 receives service should pay a nominal fee for it.  
9 My only thought in this respect is that it might  
10 help to get away from the abuse of the service. If  
11 all services are free some citizens may be inclined  
12 to go for service much oftener than they really need  
13 to or get treatment much longer than should be  
14 necessary. Now, whether or not a combination of  
15 those two could be used I do not know.

16 THE CHAIRMAN: We have had one or two  
17 provinces suggest that the free might be \$12.00 for  
18 a single person and \$24.00 for a family -- I mean  
19 the premium.

20 DR. HANNAN: I think that would be satisfactory.  
21 That is, I do not think we would think of it being  
22 lower than that.

23 THE CHAIRMAN: You use the word "comprehensive".  
24 Now, have you a meaning you wish to attribute to that?  
25 When you advocate a comprehensive program we would  
26 like to know what view you encompass in it because  
27 you have excluded three, optical ---

28 DR. HANNAN: Optical, dental ---

29 THE CHAIRMAN: And perhaps drugs.

30 DR. HANNAN: Yes.







1 THE CHAIRMAN: What does "comprehensive" --  
2 what do you mean by "comprehensive" excluding those  
3 three and then with a certain reservation about  
4 psychiatric services.

5 DR. HANNAN: Well, we mention particularly  
6 medical, surgical, but then we are thinking in using  
7 the word "comprehensive" of an overall total health  
8 program where they would not only treat for illness  
9 but would also carry preventive medicine practices,  
10 promote nutrition, better diets and so forth  
11 through public promotion, through schools and  
12 hospitals, and clinics and so forth, organized,  
13 co-ordinated and directed by the national program.

14 THE CHAIRMAN: In the same paragraph on page  
15 12 this is your opening sentence on your declaration  
16 of principle:

17 "That the federal government  
18 adopt as a policy the implementation  
19 of a national compulsory medical  
20 care insurance program to be carried  
21 out in cooperation with the  
22 provinces."

23 MR. HANNAN: Yes.

24 THE CHAIRMAN: But the use of the word  
25 "compulsory" would you spell out what you mean by  
26 compulsory in that declaration of principle?

27 DR. HANNAN: Perhaps we might have used  
28 the word "general" but we are thinking of it as  
29 a program that applies to all citizens and gives  
30 service to all citizens.





1 THE CHAIRMAN: Applies to all. Do you  
2 mean by that it will be available to all?

3 DR. HANNAN: Yes.

4 THE CHAIRMAN: And do you also mean that  
5 all should contribute by way of this premium if they  
6 are able to pay?

7 DR. HANNAN: Yes, outside of indigents if  
8 they are able to pay.

9 THE CHAIRMAN: So you have in mind that a  
10 person who has the ability to pay and may wish to  
11 pay privately should also contribute to the program  
12 that you advocate?

13 DR. HANNAN: Yes.

14 COMMISSIONER VAN WART: Do you include  
15 Indians and war veterans and so on in that?

16 MR. KIRK: Well, I certainly think the  
17 intent of our belief is that the entire population  
18 should be covered. There are programs now, how  
19 adequate they are I do not know, related to war  
20 veterans and Indians.

21 THE CHAIRMAN: You would foresee an  
22 integration?

23 MR. KIRK: Oh, yes.

24 THE CHAIRMAN: Whether it is the Indian or  
25 the veteran, those who are able to pay you would  
26 expect them to make a contribution by way of this  
27 premium?

28 DR. HANNAN: We think it would be fair for  
29 all.

30 THE CHAIRMAN: I do not want to put words in





1 your mouth -- is that it?

2 DR. HANNAN: Yes.

3 COMMISSIONER VAN WART: On page 10 paragraph  
4 33 you say:

5 "The development of what  
6 would virtually be a great public  
7 utility ---"

8 Have you given any consideration where the  
9 administration of this utility would be in a  
10 department of government or in a separate commission  
11 or have you given any consideration how it would be  
12 operated federally?

13 DR. HANNAN: No, I am sorry, we do not.  
14 There are many details in this we have not gone into  
15 and that is one.

16 COMMISSIONER STRACHAN: Mr. Chairman, I  
17 think it would be interesting to the Commission to  
18 have Dr. Hannan's definition or explanation of  
19 what he means by the lowest income group which is  
20 used repeatedly.

21 DR. HANNAN: I do not know whether we can  
22 define it in any way except as we have said that  
23 low income groups may be able to afford \$2.00 a  
24 month or \$3.00 a month but there are certainly,  
25 many, many low income groups in Canada who could  
26 not afford any more than that.

27 COMMISSIONER STRACHAN: Yet you would  
28 not have anybody pay more than they would?

29

30







1 DR. HANNAN: No. Our thought is a  
2 general fee for all families, and all citizens. As  
3 we mentioned in the presentation that we made in 1942,  
4 we had suggested a non-contributory plan but we have  
5 modified our views and recommended the nominal payment,  
6 or a small payment.

7 COMMISSIONER STRACHAN: You definitely  
8 do not feel those who can afford to pay should pay?

9 DR. HANNAN: It is true that their pay-  
10 ment would be small, certainly to them.

11 THE CHAIRMAN: You mean that initial  
12 payment?

13 DR. HANNAN: Yes, the initial payment.  
14 Certainly they may ask and get extra services but in  
15 any case they will be paying through the taxes. They  
16 will pay more than others will through their taxes.

17 COMMISSIONER STRACHAN: Essentially  
18 this is a tax-supported idea which you are suggesting?

19 DR. HANNAN: Largely.

20 COMMISSIONER STRACHAN: With the adop-  
21 tion of your suggestions do you feel that the recruitment  
22 of medical personnel would be a problem at all?

23 DR. HANNAN: Well, we wouldn't know  
24 about that.

25 COMMISSIONER STRACHAN: Do you think  
26 it is worth experimenting to that extent: Decreasing your  
27 medical personnel over the years as has happened in  
28 Great Britain already?

29 DR. HANNAN: It has happened there.  
30 I don't know whether it needs to happen.





1 COMMISSIONER STRACHAN: It will happen.  
2 Needs to or not, it will. Have you any assurance it  
3 will not?

4 DR. HANNAN: We are not sure that it  
5 will happen.

6 THE CHAIRMAN: Did you put the question  
7 as to why the recommendation of dental service was  
8 excluded?

9 COMMISSIONER STRACHAN: I was taking  
10 that as a statement of fact.

11 THE CHAIRMAN: I was just wondering  
12 what the reasoning behind it was.

13 DR. HANNAN: I think that it might be  
14 right for me to say that if we are going to adopt a  
15 national health insurance program, that if we can cover  
16 medical and surgical first and make a success of it,  
17 we can then at any appropriate time move into dental  
18 and other services. This is part of our thought. To  
19 add optical and dental all at once with medical and  
20 surgical would be a tremendous program and more difficult  
21 to get started than it would be to start with medical  
22 and surgical.

23 THE CHAIRMAN: Does that imply, in your  
24 judgment, that there is a greater need for this expansion  
25 in the medical and surgical than there is in dental or  
26 the others that you would postpone?

27 DR. HANNAN: No, I wouldn't say there  
28 is a greater need but it is probably a bit more funda-  
29 mental to have medical service developed first. We  
30 leave quite open the question of dental service. That







1 is, we are not saying that it should not be included,  
2 but we are leaving it to the future to decide that and  
3 how it might be added.

4 COMMISSIONER VAN WART: Would you  
5 believe in a program to lessen dental disease by  
6 research?

7 DR. HANNAN: Yes, by all means. I  
8 don't know whether we have mentioned as thoroughly as  
9 we might have done that we would support certainly any  
10 expanded research and education all through the health  
11 field.

12 COMMISSIONER VAN WART: Has your  
13 Association taken a stand on fluoridation?

14 DR. HANNAN: No. It has never arisen  
15 with us. It has never come up from any of our locals  
16 as a resolution and yet we have dealt with about 100 a  
17 year at our annual meeting. We have never had one on  
18 fluoridation.

19 THE CHAIRMAN: The question of communal  
20 water supply does not arise quite frequently on the  
21 farm?

22 DR. HANNAN: Water supply is often a  
23 very serious matter.

24 THE CHAIRMAN: It is an individual  
25 problem.

26 DR. HANNAN: Yes.

27 COMMISSIONER BALTZAN: Dr. Hannan, on  
28 page 4, last paragraph; I am very much interested in  
29 your statement of the constitution of the World Health  
30 Organization and the particular phrase:





1 "Governments have a responsibility for  
2 the health of their peoples which can  
3 be fulfilled only by the provision of  
4 adequate health and social measures".

5 Now, have you gone into the definition  
6 of the term "adequate health"? That can be divided,  
7 and has been for a long time divided, relative to govern-  
8 ments' responsibility, into public health. That is the  
9 original conception and also latterly into the field of  
10 personal health.

11 In the original intention of the World  
12 Health Organization the adequate health feature, to the  
13 best of my knowledge, and I am asking for any directions  
14 or better interpretation, refers chiefly to public health  
15 measures such as preventative, hygienic measures. Some  
16 things that are mentioned already: water pollution, epi-  
17 demics of one kind or another.

18 Do you, in your statement, include  
19 under adequate health, both public health which govern-  
20 ments have already done in most civilized countries,  
21 have carried that out, and now also include personal  
22 health?

23 DR. HANNAN: Yes, we do.

24 COMMISSIONER BALTZAN: I just wanted to  
25 have your opinion. Now, you say governments have respon-  
26 sibility for the health of their peoples. Does it  
27 follow that governments assume a responsibility if indi-  
28 viduals neglect themselves?

29 DR. HANNAN: Perhaps.

30 COMMISSIONER BALTZAN: I mean, I am not







1 trying to be facetious but one thing sort of seems to  
2 follow upon another. I might even quote another one.  
3 If that is the case could individuals be accused of  
4 neglect or held guilty for not looking after themselves?  
5 The Government has that responsibility if you are going  
6 to carry it through; that responsibility might even go  
7 so far as to make certain people behave themselves.

8 DR. HANNAN: We do that with education,  
9 don't we?

10 COMMISSIONER BALTZAN: Yes, up to a  
11 point, until we get to be mature.

12 DR. HANNAN: In other words, I think  
13 it is possible for an enlightened democracy to set a  
14 higher ideal for the health of the nation than all indi-  
15 viduals will agree to or have thought their way through  
16 and therefore that the nation can give leadership.

17 COMMISSIONER BALTZAN: I agree with  
18 you. I am not trying to be hypothetical. I want to be  
19 as practical as possible. I want to know how you think  
20 these things can be implemented. I am almost inclined  
21 to think that it is taken literally, and I ask you  
22 could people be forced to protect themselves to protect  
23 governments in their responsibility to see that people  
24 look after themselves?

25 I mean, there seems to be a number of  
26 implications.

27 DR. HANNAN: To some extent, I think  
28 we do that now in some fields. Contagious diseases,  
29 for example.

30 THE CHAIRMAN: That is in the public







1 health field.

2 DR. HANNAN: Yes.

3 THE CHAIRMAN: The doctor is talking  
4 about the personal health field.

5 DR. HANNAN: It may be difficult to  
6 administer but still I think it would be justified.

7 COMMISSIONER BALTZAN: Yes, I am still  
8 trying to be as practical as possible and carry this  
9 thing through logically. On page 6, Section 21, we  
10 have heard the statement before about the number of  
11 people that are not covered, etc. I can't remember  
12 that we have gotten anywhere the thing I would like to  
13 see some time answered: how many people do not want to  
14 be covered or do not care to be covered; have not the  
15 means to cover themselves, so that this thing doesn't  
16 stand out as boldly as that 83.2% in your figures?

17 Have there been any studies? Have you  
18 come across any?

19 MR. KIRK: Except that it has been  
20 shown that the higher income groups tend to protect  
21 themselves to a greater percentage than the middle  
22 income group that might perhaps be assumed to have the  
23 means and the higher income group still having - if I  
24 recall rightly, I think there was a very slight decline  
25 on the part of the higher income group until they got to  
26 where there was no perceptible decline.

27 THE CHAIRMAN: Until they got to the  
28 ones that had gout.

29 MR. KIRK: In the desire for coverage,  
30 that would be the only evidence I recall seeing on that





1 point.

2  
3 COMMISSIONER BALTZAN: Just one last  
4 point in following up the Chairman's lead-in question,  
5 in relation to separating so-called mental, emotional  
6 needs from the physical or organic, we have heard it  
7 from very good authority on a number of occasions  
8 something in the neighbourhood of 50% of the people who  
9 go to visit doctors call on them for emotional, psycho-  
10 logical disturbances and if you pursue your statement  
11 here it is going to be rather hard on a large percentage  
12 of the people who still need medical service, doctors'  
13 services, nursing services, unless that is also included  
14 in the total health program.

15 Does that change your view at all?

16 MR. KIRK: Unless mental services are  
17 included?

18 COMMISSIONER BALTZAN: That is a very  
19 broad term for anything.

20 MR. KIRK: It was our intention they  
21 should be included in the appropriate form. Our only  
22 thought was what was the appropriate form for the  
23 inclusion of those services.

24 COMMISSIONER BALTZAN: If you do sir  
25 it would be of very great help because sometimes it is  
26 very difficult to separate symptoms coming from organic  
27 and other causes.

28 THE CHAIRMAN: Is this what you mean?  
29 Are you saying that under your scheme a general practi-  
30 tioner and most specialists would be paid on a fee-for-  
service basis but that you think it is impractical to







1 pay the specialists in the psychiatric field on that  
2 basis and that he be on a salary basis attached to an  
3 institution? Is that what you mean?

4 DR. HANNAN: Right, yes.

5 COMMISSIONER FIRESTONE: On that last  
6 point Dr. Hannan, if the medical practitioner, or as  
7 Dr. Baltzan suggested, every second patient may have  
8 some ailment that is mental distress or mental distur-  
9 bance as the cause and effect, you would still pay that  
10 medical practitioner, under your proposed scheme, on a  
11 fee-for-service basis? Is that correct?

12 DR. HANNAN: Yes.

13 COMMISSIONER FIRESTONE: Now sir, if I  
14 may follow up the question that Dr. Baltzan raised when  
15 he asked you whether the Canadian Federation of Agricul-  
16 ture supported this principle of the World Health Organi-  
17 zation that governments have a responsibility for the  
18 health of their peoples which can be fulfilled only by  
19 the provision of adequate health, social measures; I  
20 take it you subscribe to this principle as applicable  
21 to the personal health service field?

22 DR. HANNAN: Right.

23  
24  
25 -  
26  
27  
28 -  
29  
30





1 COMMISSIONER FIRESTONE: Now, in the personal  
2 health service field you feel that all expenditures  
3 covering such services should be prepaid through  
4 some scheme or another. Are you in favour of the  
5 prepayment principle?

6 DR. HANNAN: In general I am, yes that is  
7 what our organization subscribes to.

8 COMMISSIONER FIRESTONE: You mentioned that  
9 this had not been discussed in detail, and I have  
10 said that I have often thought that a small nominal  
11 fee might help to prevent abuses if it was considered  
12 wise to do that. What your Association is after,  
13 if I understand you correctly, is the number of  
14 measures designed to improve general health of the  
15 Canadian nation.

16 DR. HANNAN: Yes.

17 COMMISSIONER FIRESTONE: You realize that for  
18 practical considerations some programs can be  
19 introduced sooner and some programs later.

20 DR. HANNAN: Yes.

21 COMMISSIONER FIRESTONE: But your ultimate  
22 objective is total coverage in all areas of the health  
23 field. Is that your ultimate objective over a  
24 period of time?

25 DR. HANNAN: I think it would be right for  
26 me to say yes, because we have endorsed that in the  
27 past, and I think as time goes on that our people  
28 and perhaps Canadian people generally will move in  
29 that direction.

30 COMMISSIONER FIRESTONE: In other words, while







1 you have put in a specific recommendation for  
2 comprehensive and compulsory medical care program,  
3 you feel that a complete health program over a period  
4 of time should include some of the other things  
5 that are not covered so far, because we already  
6 have hospitalization, and if your proposition should  
7 be adopted we should have medical care.

8 DR. HANNAN: Yes.

9 COMMISSIONER FIRESTONE: And at another stage,  
10 if the resources of the country permit it and there  
11 are enough practitioners available and enough  
12 financial resources available, other aspects may be  
13 covered, and this would include dental health  
14 services and prepaid drugs as far as the prescribed  
15 drugs by physicians and optical care as well.

16 DR. HANNAN: Yes.

17 COMMISSIONER FIRESTONE: So you are  
18 envisaging a long-term program in stages.

19 DR. HANNAN: Yes. Well, I can't say at this  
20 annual meeting our resolution would include that  
21 clause, but I am sure it has been in the minds of  
22 our people that we are moving in that direction.

23 COMMISSIONER FIRESTONE: And would you say  
24 that your membership would support a gradual program  
25 developed over a period of time with the ultimate goal  
26 of covering all the major aspects of health services?

27 DR. HANNAN: I am confident that it would.

28 COMMISSIONER FIRESTONE: Thank you very much.

29 DR. HANNAN: And I think we can say that  
30 with some confidence, because for twenty years now --







1 it has been twenty years since we adopted our first  
2 program of national health insurance, and we have  
3 had it improved repeatedly in the twenty-year period.

4 COMMISSIONER FIRESTONE: Now, sir, I would  
5 like you to come back to your paragraph 2 on the  
6 first page, subsection (b), in which you say your  
7 Association, your federation recommends the federal  
8 government adopt as a policy the implementation of  
9 a national compulsory medical care insurance program  
10 in cooperation with the provinces. I appreciate  
11 that there are different views held whether such  
12 programs should be undertaken at all or not, and  
13 if they are undertaken whether they should be  
14 compulsory or voluntary.

15 Now, sir, people have put forward these  
16 viess, that they cannot see many people in Canada  
17 who are going without medical care services. Why  
18 should there be a compulsory health program where  
19 nobody, in fact, is lacking a health service in  
20 Canada. Would you agree with that point of view?

21 DR. HANNAN: I wouldn't agree with that  
22 point of view, because there are people, and I think  
23 the substantial portion of our people, who go without  
24 substantial medical health services. I think the  
25 proportion of our population is too large to make  
26 that statement.

27 COMMISSIONER FIRESTONE: Have you had any  
28 evidence amongst your membership that would support  
29 this thing? We are getting one statement from one  
30 group of people and another statement from another





1 group of people, but based on your experience -- and  
2 you have a large membership across Canada -- based  
3 on your experience, have you any evidence to support  
4 that the claims that have been put before this  
5 Commission that there is nobody in Canada going without  
6 adequate medical care services are justified, based  
7 on your own experience, because either it is justified  
8 or it is not justified, and if it is not justified,  
9 you have made a good case for a compulsory program,  
10 and if it is justified, then where is your case?

11 DR. HANNAN: Mr. Chairman, I made our  
12 justification for our case in 1942, and I have been  
13 at all meetings of the Federation in the meantime  
14 and I have yet to find any view put forward by any  
15 of our officials or any delegates in our meetings  
16 to the contrary. There has been almost no voicing  
17 of opposition to this program, in our Federation  
18 meetings.

19 COMMISSIONER FIRESTONE: In other words,  
20 you are saying it is based on the conviction and the  
21 knowledge of your membership that there is a  
22 definite need for such a program, and without it  
23 a lot of people are going without medical care  
24 services. Is that what you are saying?

25 DR. HANNAN: I believe that is absolutely  
26 right.

27 COMMISSIONER FIRESTONE: Now, sir, another  
28 criticism that has been made of your program of a  
29 compulsory program, and that is why should it  
30 include people who are with adequate financial means







1 and who wish to look after their own arrangements,  
2 to pick the doctor as they like and pay as they like,  
3 they are in a financial position to do so, and, if  
4 so, why include these people in this group in a  
5 compulsory medical care plan? What are your  
6 views on this subject?

7 DR. HANNAN: Well, there is some support  
8 for that point of view unquestionably, but if you  
9 wish to have a complete national health service that  
10 is planned for all, I think it seems best, if you  
11 want to have this program properly organized and  
12 coordinated and worked out, that -- we have said  
13 in here that we have the right to choose the doctor,  
14 the people with more money than average will ask  
15 for extra services and pay for them --

16 COMMISSIONER McCUTCHEON: What extra services  
17 do you envisage there? I thought this was a  
18 comprehensive health service program?

19 DR. HANNAN: Well, they may ask for doctors'  
20 services which may not ordinarily be provided by  
21 the program.

22 COMMISSIONER McCUTCHEON: What services  
23 would you eliminate from the program?

24 DR. HANNAN: I was not eliminating any.

25 COMMISSIONER McCUTCHEON: No, but what  
26 services would you exclude? A regular physical  
27 examination once a year? What kind of services  
28 are going to be paid for over and above the plan?  
29 I notice that Saskatchewan excludes the one I  
30 mentioned.





1 DR. HANNAN: Again those are details, but  
2 my point is that once you develop a plan of this  
3 kind you have to have regulations for it, and that  
4 the well-to-do family will say: "Well, I want  
5 something more than is provided by these regulations."

6 COMMISSIONER MCGUTHCHEN: There would be  
7 a case in which a private practitioner could still  
8 operate in the manner he does today; he wouldn't  
9 have to operate entirely within the plan?

10 DR. HANNAN: I would think so.

11 COMMISSIONER FIRESTONE: You say, sir, the  
12 reason you feel that this group of people who are  
13 financially independent, a small proportion of the  
14 total population, should be included under such a  
15 compulsory national health program on the ground  
16 that such a program should, in the interest of  
17 comprehensiveness and national coverage, include the  
18 [redacted] these services, together  
19 with a majority that can afford [redacted] but  
20 at times may find it very difficult to pay for them.  
21 In other words, you feel that a majority of people  
22 would be benefitting by this program and, in the  
23 interest of the national program, that people who  
24 wish to make their own arrangements should still be  
25 included. Is that your point, sir?

26 DR. HANNAN: Yes.

27 COMMISSIONER FIRESTONE: Now, in the same  
28 paragraph under 2(b) you say that such a program  
29 should be developed in cooperation with the provinces.  
30 Do I understand from that that you are visualizing





1 the role of the federal government to make a  
2 contribution to a provincially-operated and  
3 administered medical care plan similar to what is  
4 being done, say, in the field of hospital insurance,  
5 or do you visualize a national plan operated by  
6 the federal government worked out in cooperation with  
7 the provinces?

8 DR. HANNAN: We haven't studied that. There  
9 is, I think, a rather generally held belief that the  
10 way the hospital program is being carried out is  
11 the best under our constitution. If that is so,  
12 then we would be satisfied.

13 COMMISSIONER FIRESTONE: In other words,  
14 you would go along with a plan that provided a  
15 federal contribution to the provinces in setting up  
16 a medical care plan in each province?

17 DR. HANNAN: So long as the federal program  
18 had some right of coordination and so forth.

19 COMMISSIONER FIRESTONE: Providing there  
20 will be some conditions attached to this  
21 program, minimum standards, and so on, transferability  
22 from one province to another. In other words, make  
23 it a national program in fact.

24 DR. HANNAN: Yes, in the interests of  
25 equity and a national standard of health.

26 COMMISSIONER FIRESTONE: And in order not  
27 to put any obstacles in the way of mobility, for  
28 example. That is your point?

29 DR. HANNAN: That is right.

30 COMMISSIONER FIRESTONE: Now, sir, we have







1 been encountering in some of the provinces suggestions  
2 that perhaps they would like medical care plans but  
3 on a voluntary basis; some provinces prefer it  
4 compulsory and others have no views on whether one  
5 or the other should be implemented. But let's  
6 assume that some provinces prefer to have a voluntary  
7 plan and others a compulsory plan. We are here to  
8 advise the federal government, we are not here to  
9 advise the provincial governments. Now, if such  
10 a situation should arise, could you visualize a  
11 program and would your Federation support a program  
12 provided the federal government may make financial  
13 contributions to provinces, some provinces providing  
14 contribution on a compulsory basis, some on a  
15 voluntary basis, providing cover for 85 per cent,  
16 95 per cent of the population, and if such were  
17 the sort of policy one tries to work out in order  
18 to take care of the different wishes of people in  
19 the different provinces and the views held by the  
20 provincial governments, would your association  
21 support such a federal program?

22 DR. HANNAN: I would say we haven't thought  
23 about it, but I would see no objection to it. As I  
24 say, we are not dogmatic about a program. We still  
25 have a democratic country, and we have been fairly  
26 flexible with respect to our constitution, and I  
27 see no harm in being flexible if such a program  
28 became federal.

29 THE CHAIRMAN: So you would have to give  
30 way on the compulsory aspects of your program to that  
extent.





1 DR. HANNAN: This is our ideal, but  
2 we hadn't considered this other thought. I think our  
3 Federation would go along with that, if that is the  
4 practical point of view, if that is the best way to do  
5 a national program. I don't see why we should compel  
6 a province to do it this way, even if the way that they  
7 choose might not in the long run be the best.

8 Some experimentation would not hurt.

9 THE CHAIRMAN: Just carrying the  
10 matter one step further, supposing all the provinces  
11 said they would do it on a voluntary basis, would you  
12 be willing to go along and drop the word compulsory  
13 from your recommendation? That is, do you favour a  
14 program that would be voluntary in the ten provinces,  
15 if such a program were to be recommended?

16 DR. HANNAN: Do you mean a general  
17 program.

18 THE CHAIRMAN: Yes. You conceded  
19 that you would accept it for several provinces. I  
20 wondered if you would go so far as to accept it for  
21 all. I am just trying to get the logical implication  
22 of your answer to Dr. Firestone.

23 MR. KIRK: Our recommendation is as it  
24 is.

25 THE CHAIRMAN: For compulsion?

26 MR. KIRK: Yes, but it would certainly  
27 be correct to say, I think, that our people would not  
28 want to see nothing done in pursuance of a rigid adhe-  
29 rence to this. They would like to have three-quarters  
30 of a loaf rather than no bread at all.







1 COMMISSIONER FIRESTONE: Your view is  
2 that you prefer a voluntary rather than a compulsory  
3 national program, but you would accept another as long  
4 as it is national in scope, with a small premium and  
5 the bulk of the cost paid in tax?

6 DR. HANNAN: Yes, that is our view.

7 COMMISSIONER FIRESTONE: On page 3,  
8 in paragraph 7, you make reference to the hospital  
9 insurance program. Can you tell us whether your Associa-  
10 tion is satisfied with the operations of the hospital  
11 insurance program as it is now in operation in Canada?

12 DR. HANNAN: I think the only answer  
13 I can say is that we have not had complaints, and I  
14 think that is a fairly good answer.

15 THE CHAIRMAN: We are taking it that  
16 the word satisfied is in general terms, that we are  
17 not down to any detail?

18 DR. HANNAN: Yes, generally we get the  
19 impression that it is generally satisfactory.

20 THE CHAIRMAN: Well now, before you  
21 commit yourself completely to that, have there not been  
22 very widespread statements that it is a mistake to  
23 exclude both tuberculosis and mental health from this  
24 operation?

25 DR. HANNAN: Well, we haven't had  
26 that coming from our organization. That is all I can  
27 say. Yes, we hear that criticism, but we haven't had  
28 it come forward to us.

29 COMMISSIONER FIRESTONE: I am wondering  
30 whether you have had perhaps - perhaps you have not had





1 adequate opportunities to consult your members on some  
2 specific questions, and it may well be that you might  
3 be able to answer one or two of the questions subse-  
4 quently, after some more consultation, so please feel  
5 free in answering the next questions I am going to ask,  
6 to say we haven't had any consultation and we will let  
7 the Commission know at some later date. And this  
8 applies to all questions.

9 DR. HANNAN: Yes, we would be happy to.

10 COMMISSIONER FIRESTONE: The specific  
11 question I wanted to raise, following up what the  
12 Chairman has just been saying, is that there is a provi-  
13 sion under the hospital insurance program for federal  
14 participation for the costs of out-patient treatments,  
15 and most of the provinces have not made use of that  
16 provision.

17 I am just wondering has this question  
18 come up, because I would presume if I lived in a rural  
19 area and I had something wrong with me and I cannot get  
20 a doctor, the quickest way would be to take my car or  
21 truck and drive to the nearest hospital and have this  
22 thing taken care of as an out-patient, and I hope that  
23 if I am in a farming community that this would be taken  
24 care of, particularly since there is a legislative provi-  
25 sion which permits it.

26 If this question has not been discussed,  
27 could we have some views after further consideration?

28 DR. HANNAN: Yes, we haven't had that  
29 arise.

30 COMMISSIONER FIRESTONE: You appreciate







1 the importance of this point to the farming population  
2 as far as health services?

3 DR. HANNAN: I know that we would get  
4 support for it.

5 THE CHAIRMAN: You know that that is  
6 the position in Manitoba today, where the provisions  
7 of the Hospital and Diagnostic Services Act have been  
8 taken advantage of, and is in operation in Manitoba.  
9 It is the one province that has exercised its rights in  
10 that respect, but perhaps there may be some opinion in  
11 the rural communities in Manitoba.

12 DR. HANNAN: Yes, we would be very  
13 happy to look into that matter, or any others.

14 COMMISSIONER FIRESTONE: We might get  
15 a written comment on this point from you, addressed to  
16 our Secretary?

17 DR. HANNAN: Yes.

18 COMMISSIONER FIRESTONE: Paragraph 16,  
19 on page 5: you say, and I quote:

20 "We recommend that in considering all  
21 questions of public provision, planning  
22 and insuring of health service, the  
23 need of citizen education and partici-  
24 pation be constantly kept in mind".

25 Now, we appreciate, Dr. Hannan, that  
26 you have tried to put your views forward in fairly  
27 general terms, but it would help the Commission if you  
28 would, on occasion, spell out in some more specific  
29 terms what you have in mind, because we, as Commissioners,  
30 have to come forward with specific recommendations, and







1 if we can have help from various groups it is particu-  
2 larly appreciated.

3 Do you have any specific points in  
4 mind when you say there is need for citizen participa-  
5 tion and education? How can this be achieved? And  
6 again, sir, if you wish to give further consideration  
7 to the point and let us know your answer in writing,  
8 please feel free to say so.

9 DR. HANNAN: We would be glad to do  
10 that for that one as well.

11 COMMISSIONER FIRESTONE: Thank you  
12 very much. In paragraph 17, page 5, you make reference  
13 at the bottom of the paragraph to the greater incidence  
14 of sickness, and you say that in your opinion this is  
15 likely, or it may be mainly due to a lower level of  
16 provision of medical services. I am just wondering  
17 what you mean by a lower level of provision of medical  
18 services. Does it mean that a farmer living in a rural  
19 area cannot get doctor services? What does this mean,  
20 a lower level of provision of medical services for the  
21 rural areas?

22 MR. KIRK: Well, I think again the  
23 only really specific evidence we had on that point was  
24 the fact that in this sickness survey, you had this  
25 dual situation, that there was a greater incidence of  
26 sickness and debility and a lower incidence of cause  
27 and actual service given, and we thought that this  
28 reflected a less adequate level of medical services.

29 THE CHAIRMAN: The lower level of the  
30 provision means that it is harder for them to get to the  
services?





1 MR. KIRK: Right. If the statistics  
2 had shown that there was ---

3 THE CHAIRMAN: By not being able to  
4 get the medical services, is it because of the transpor-  
5 tation problem, or because there is an inadequate  
6 number of doctors?

7 DR. HANNAN: As far as the population,  
8 together with the distance from the hospital or doctor,  
9 and also a snowstorm, that the doctor cannot get out,  
10 and so forth.

11 COMMISSIONER FIRESTONE: On page 7,  
12 the top of paragraph 23, you object to patients being  
13 treated on the charity of the doctor, or at the expense  
14 of other patients. We have been told by many of the  
15 medical associations appearing before us that doctors  
16 are quite happy to look after indigent patients, or  
17 patients who cannot pay. What are your objections?

18 DR. HANNAN: The doctor must be paid,  
19 surely, and if he operates his office and gives his  
20 time and does the travel, and then provides services  
21 free to an indigent, he has certainly got to get paid  
22 somewhere, and so therefore he gets paid from those who  
23 pay the bills, or if he does not charge a little more  
24 for others, then it is charity on his part. This is  
25 what we meant.

26 COMMISSIONER FIRESTONE: Yes, in other  
27 words what you are saying is that first of all you are  
28 in favour that the doctor should be paid his proper  
29 fee for the services he renders?

30 DR. HANNAN: Right.







1 COMMISSIONER FIRESTONE: Secondly, you  
2 are saying that the present system where a doctor will  
3 treat one patient for nothing, and charge another  
4 patient a higher fee, places an additional burden on  
5 people who are sick and can pay for it, and you favour  
6 a system where medical services are prepaid with a  
7 modest premium, and the remainder paid out of taxes,  
8 on the basis of ability to pay. Is that your view?

9 DR. HANNAN: That is right.

3 10 COMMISSIONER FIRESTONE: Thank you sir.  
11 On page 11, in paragraph 35, you make the statement,  
12 and I quote:

13 "Any idea that all these problems can  
14 be taken care of properly, fairly and  
15 with the dignity to the individual by  
16 vast adoption of special subsidization  
17 of voluntary plans and by a means test,  
18 that the problem would take care of  
19 itself in any reasonable time without  
20 such stratagems - strikes us as unrea-  
21 sonable".

22 What are your objections against the  
23 means test? It has been suggested to us by a number  
24 of groups that perhaps the people who cannot afford to  
25 pay for medical care services should be taken care of  
26 by State payment on the basis of a means test, and that  
27 others, that can take care of these because they are in  
28 a financial position to pay, should make increasing use  
29 of a voluntary plan. It may well involve, if one wished  
30 to have universal coverage, a substantial increase in the





1 number of means tests. You are objecting to those  
2 means tests. Why? Many other groups say they are in  
3 favour, and you say you are against.

4 DR. HANNAN: I don't think our sentence  
5 actually means that. Does not it mean that if it is  
6 done in any of these ways, the means test is one, it  
7 is a hit and miss plan. That is all. Here we say  
8 special subsidization of voluntary plans. Now, we are  
9 not opposed to voluntary plans, and therefore we are  
10 not saying that we are opposing means tests. We are  
11 just saying that if it is done by a number of these  
12 methods, it can be a hit and miss basis that is not  
13 satisfactory to all citizens.

14 COMMISSIONER FIRESTONE: I appreciate,  
15 sir, that you are not saying that a means test is  
16 desirable or undesirable, but others are saying it is  
17 desirable. Does the Federation agree with groups who  
18 come before this Commission and say "We are in favour  
19 of using the means test" or whether you are not in  
20 favour?

21 MR.KIRK: It strikes us, if you think  
22 that first of all you are going to cover as many people  
23 as you can by voluntary plans, and then if their income  
24 is low, and you have to decide how low it should be, or  
25 if they are indigent, and you have to decide if they  
26 are indigent, if they are unemployed, or excluded  
27 through chronic illness and previous condition, and you  
28  
29  
30







1 have to have some means of them making application for  
2 coverage under these conditions, and so on, it seems to  
3 us that it is to some extent an undignified procedure  
4 for individuals. It puts to some extent a stigma of  
5 charity on a service that we suggest as a fundamental  
6 principle should be a socially-provided service as a  
7 matter of right, and in addition to this, it is very  
8 complicated, unwieldy, and perhaps for many individuals,  
9 an extremely difficult thing, even to understand what  
10 they have to do, when they should do it and so on, and  
11 so on.

12 It seems to us altogether too compli-  
13 cated and difficult, and in some ways wrong.

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1 THE CHAIRMAN: I do not want to prolong it  
2 but you advocate the premium, the collection of a  
3 premium except from those who are unable to pay.  
4 Now, how are you going to identify those who are  
5 unable to pay without some form of test to which  
6 you have spoken in such disparaging terms.

7 MR. KIRK: Well, it is true it is a minimum,  
8 really a means test requirement but it is a minimum.

9 THE CHAIRMAN: You have to recognize that  
10 the means test is something that cannot be avoided  
11 at some stage.

12 MR. KIRK: To keep it to a minimum, we  
13 need not proliferate the requirement.

14 COMMISSIONER FIRESTONE: And you feel in  
15 such a program as you have described you would  
16 keep it to an absolute minimum?

17 B. KIRK: Yes.

18 COMMISSIONER FIRESTONE: Now turn to page  
19 13, paragraph 38 which we read with great interest;  
20 your appendix C in which you have indicated your  
21 views about drug costs in Canada. Just for the  
22 benefit of this Commission I take it that you are  
23 concerned with what is described as the high cost  
24 of drugs?

25 B. HANNAN: Yes.

26 COMMISSIONER FIRESTONE: Would you feel it  
27 would be desirable to include a study of why costs  
28 of drugs are high in relation to total health costs  
29 and whether they are really high and why, supplementing  
30 the work that has been done by other groups including





1 the Restrictive Trade Practices Commission.

2 MR. KIRK: Yes, I would think we would.

3 THE CHAIRMAN: What would you contemplate  
4 by such a study?

5 MR. KIRK: Well, we started from this  
6 point that there was an investigation by the  
7 Director of Research that seemed to us to very clearly  
8 indicate that we were paying prices for drugs that,  
9 in our judgment, reading that, was thoroughly  
10 excessive. Now, it was very evident in approaching  
11 this question before the Commission that while the  
12 Restrictive Trade Practices Commission itself has  
13 certain legal responsibilities that this perhaps  
14 is, in fact unquestionably their area of  
15 responsibility won't necessarily meet this problem --  
16 probably won't meet this problem. They made their  
17 study from a very fairly closely defined legislative  
18 authority which leaves out, I am sure, a number of  
19 aspects on the question and all we saying is that  
20 we still think the price of drugs is too high.  
21 We agree with that, we think that finding shows that.  
22 We feel that further research and investigation and  
23 policy of recommendations for a legislation or  
24 practice that are needed to contribute to reducing  
25 these costs should be undertaken. What precisely  
26 that would be I do not know.

27 THE CHAIRMAN: Undertaken by whom?

28 MR. KIRK: Well, if it is within the  
29 time and ability of the Commission I would think  
30 the Commission could very appropriately do that.







1 COMMISSIONER FIRESTONE: You suggested  
2 earlier, if I understood you correctly, that you  
3 felt there were certain excessive drug costs that  
4 should perhaps be taken care of in the immediate  
5 future as distinct from a longer term program,  
6 presumably if the Commission would make any  
7 recommendations of meeting such health costs  
8 we ought to know what those drug costs should be.  
9 We should look into the question of what those  
10 drug costs are before we can make any recommendations.  
11 Presumably, also, why the costs of such drugs are  
12 really high or whether they really are high; is  
13 that your view?

14 DR. HANNAN: Our thought there was why  
15 we did not recommend that drugs be included in  
16 our national plan we said there were cases where  
17 a very unusual amount of drugs are used to treat  
18 some people and if this is an excessive cost, the total  
19 cost -- we are not thinking of the drugs in  
20 this case -- if there is an excessive cost there  
21 may be some way provided to meet that. Now, that  
22 did not touch the question of the cost of drugs  
23 but if a proposal were considered by the Commission  
24 we would then think that there would be every  
25 reason why the Commission might look into this  
26 finding that drug costs are very high.

27 THE CHAIRMAN: Do you appreciate the  
28 Restrictive Trade Practices Commission has not yet  
29 made a report; do you accept that, Mr. Kirk?

30 MR. KIRK: Has not made a report?





1 THE CHAIRMAN: Not made a report.

2 MR. KIRK: Well, unless I have missed it  
3 I am not aware it has made a report.

4 COMMISSIONER McCUTCHEON: No, it has not  
5 made a report.

6 COMMISSIONER FIRESTONE: Presumably the  
7 material is available of the Restrictive Trade  
8 Commission that has come from other sources. What  
9 we are concerned with is to understand what you  
10 mean when you say, in paragraph 38, the second  
11 line:

12 "We recommend that the  
13 Commission --"

14 Presumably this means the Royal Commission  
15 on Health Services:

16 "...interests itself in  
17 this question."

18 This question has been defined, as I  
19 understand it from the first half of the sentence  
20 as the cost of drugs being a matter of vital concern  
21 in connection with health services. What we  
22 are trying to find out is what you have in mind when  
23 you say this Commission should concern itself with  
24 the matter of the costs of drugs because it is a  
25 matter of vital concern in connection with health  
26 services.

27 MR. KIRK: Well, one recommendation that  
28 we have and, of course, this is the kind of  
29 recommendation that is very much subject to expert  
30 review and opinion because we are very much amateurs





1 in this field but we do recommend, for instance,  
2 that a publication, just one example, be made of  
3 assessing drugs and the evidence with respect to  
4 them, new drugs on a governmental basis or for  
5 information purposes. A doctor does not have to  
6 depend on the company representative to such a  
7 great extent. Now, I do not know but I would rather  
8 question whether it is completely within the ordinary  
9 field of recommendations of the Restrictive Trade  
10 Practices Commission. That would be an example  
11 of something that the Commission might review as  
12 to whether it was useful or not and if it was to  
13 so recommend that this be done. This is not  
14 only to improve the information on the price of  
15 drugs but to cut down on the very high sales costs  
16 involved with company representatives. That is  
17 one example of the kind of thing we mean.

18 COMMISSIONER McCUTCHEON: It would be  
19 interesting to see the report of the Restrictive  
20 Trade Practices Commission first?

21 MR. KIRK: I agree, it would.

22 THE CHAIRMAN: Do you go so far as to  
23 suggest price fixing of drugs?

24 DR. HANNAN: No, we did not consider that.

25 THE CHAIRMAN: Or price control?

26 MR. KIRK: Our thought had been more to  
27 get rid of the price fixing that exists.

28 THE CHAIRMAN: Are you going to substitute  
29 it with state price fixing?

30 MR. KIRK: Not if measures taken succeeded







1 in bringing down the prices without that, no.

2 THE CHAIRMAN: What do you mean by that?

3 MR. KIRK: Well, we recommended, for  
4 instance, that provincial laws be changed in provinces  
5 where they exist so that a proprietor of a drug store  
6 need not be a pharmacist. This would have very  
7 direct effects on the business of providing drugs.  
8 We recommended that drugs in Canada should no longer  
9 be patentable in Canada which would have very  
10 great implications on the import of drugs from other  
11 countries.

12 THE CHAIRMAN: You would want us to take  
13 the Italian position?

14 MR. KIRK: Yes, in that case. That is  
15 what I mean, if these things resulted in a significant  
16 reduction in the price of drugs there may well be  
17 no need for any other regulatory measures on prices.

18 COMMISSIONER FIRESTONE: You feel the  
19 question of drugs is an important one as far as  
20 it relates to health services and, therefore, as far  
21 as the cost of drugs and prices of drugs affects the  
22 cost of health services you feel this Commission  
23 should cover this with a study and come forward  
24 with recommendations to the Government of Canada  
25 as to whether these claims which are being made  
26 are correct and if they are what remedial measures  
27 should be taken, supplementing whatever other  
28 recommendations are made by the Restrictive Trade  
29 Practices Commission.

30 DR. HANNAN: That is right.





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1 THE CHAIRMAN: Thank you very much,  
2 gentlemen. It has been a very profitable afternoon.

3 DR. HANNAN: Thank you very much.  
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MR. HALL: The next submission is that of the Civil Service Federation of Canada and Mr. F.N. Whitehouse and Mr. G.K. Sammon are here to present the brief.

--- EXHIBIT NO. 191: Submission of the Civil Service Federation of Canada.

SUBMISSION OF THE CIVIL SERVICE FEDERATION  
OF CANADA.

Appearances: Mr. F.N. Whitehouse  
Mr. G.K. Sammon

MR. WHITEHOUSE: First of all, on behalf of the Federation we thank you for the opportunity of appearing before your Commission. Mr. Sammon, who hails from Victoria and who is an expert on this, will present the brief.

MR. HALL: This will be filed as Exhibit 191.

MR. SAMMON: The wide scope encompassed by the terms of reference of this Royal Commission points up the varied aspects that a review of health services must include. Every man, woman and child in Canada is directly concerned with health services and their many manifestations in our economic, social and political life. This brief of the Civil Service Federation of Canada with a total active membership of 85,000 and family members of possibly a total of 500,000 citizens, must of necessity, be broad and might be judged as representing a typical cross-section of Canadian opinion.

The members of the Federation are





1 spread over the length and breadth of this great Dominion.  
2 Its membership is dedicated to the service of all the  
3 people of Canada, and perhaps, could proudly boast of  
4 its close contact with the demands and interests of  
5 our citizenry. We hear and know of their needs, and  
6 it is with this view in mind that this brief is presented  
7 by the Federation not as an outline by our membership  
8 but as format for delineating the true health needs of  
9 the whole of Canada.

10 In reviewing the extent of health  
11 services offered to Canadians, one can only wonder at  
12 the truly high level of health and medical care we do  
13 have available. While this is true, there would seem  
14 to be many worthy areas which, as yet, have not  
15 received the fullest attention which the current needs  
16 in Canada suggest is needed. We can readily find many  
17 minor faults in what is a truly fine health programme -  
18 we have the basic framework for optimum development  
19 of health care already in existence in Canada today.  
20 It would be presumptuous, on the part of the Federation,  
21 to speak knowingly of parts of health services, yet  
22 there are many features of current health and medical  
23 practice which are well known to and of true interest  
24 to all our members.

25 Some of the areas our membership has  
26 expressed an interest include the following:

27 A. Health Care Insurance

28 With the spiralling costs for medical  
29 care, the need for prepaid health insurance becomes  
30 more apparent. At the present time there are many







1 inadequacies in the present insurance plans. There are  
2 abuses and misuses, and there are too many of our citi-  
3 zens who are unable to participate. On the other hand  
4 there are some instances which do not allow for adequate  
5 remuneration of the doctor - this seems quite apparent  
6 in many of our welfare patients. The overall field of  
7 economic support for medical care is one area in which  
8 the greatest contribution might be made through detailed  
9 study of our needs as opposed to our resources to meet  
10 these needs. Every citizen of Canada would benefit  
11 from some form of medical care insurance which might be  
12 implemented on a comprehensive basis.

13 Studies should be instituted without  
14 delay to correlate existing services offered through  
15 existing medical, surgical and diagnostic insurance  
16 plans. Such information, correlated with field surveys,  
17 of current usage of medical care plans should point the  
18 way to the most practical and economical plan for all  
19 Canadians. Such a plan should be compulsory with the  
20 premiums shared by the Government of Canada and the  
21 participants.

22 Special consideration should be devoted  
23 to the prescription of eye-glasses, hearing aids and  
24 similar appliances and equipment duly prescribed by  
25 authorized, qualified physicians, for the overall treat-  
26 ment of the patients. Consideration should be given to  
27 financing of this aspect of medical care with the ulti-  
28 mate goal being one of equal sharing of costs as outlined  
29 above.

30 Many ways of initiating such a plan







1 must be investigated. While many groups have conducted  
2 such studies, due care must be given to the fact that  
3 such a plan should be for the benefit of all Canadians  
4 and not for any vested interests - this we consider of  
5 paramount importance. Similarly, fullest consideration  
6 of maintaining existing doctor-patient relationships  
7 should be an integral feature of the plan. Complete  
8 freedom of choice of one's individual personal physician  
9 should be incorporated in any such plan. Similarly,  
10 the ability to change from one doctor to another should  
11 be incorporated as a personal choice of each patient.

12 At any one time in Canada there are  
13 large numbers of our working population, while employable,  
14 are without positions. Consideration should be given to  
15 extension of this comprehensive medical plan to such  
16 individuals at times when they might be unable to meet  
17 their financial share of such a plan.

#### 18 B. Hospital Facilities

19 With the advent of a nationwide system  
20 of hospital insurance, the situation in regard to costly  
21 hospitalization has been greatly improved. As yet,  
22 there would seem to be inadequate hospital facilities  
23 in many areas as indicated by long waiting lists for  
24 persons to enter such institutions. Continued support  
25 for construction through Federal Hospital Construction  
26 Grants and Provincial matching funds must be an integral  
27 portion of our improving health services picture.

28 There is an ever-growing need in most  
29 Canadian communities for adequate and well equipped and  
30 staffed out-patient diagnostic facilities. Over and





1 above the many useful out-patient departments of  
2 teaching hospitals, there is a crying need for facilities  
3 which could decrease expensive patient-hospital days,  
4 lower individual medical costs, and bring a higher  
5 standard of diagnostic care to our communities. Beyond  
6 the actual benefit to those medically indigent, the  
7 out-patient departments of large teaching hospitals  
8 provide a useful area for continued training, both  
9 undergraduate as well as post-graduate, of the broadest  
10 range of health personnel including doctors, nurses,  
11 laboratory, dental, x-ray technicians, physical thera-  
12 pists, etc. The variety of clinical subject matter  
13 available through these facilities is available in no  
14 other way and are another reason why the need for such  
15 departments are necessary and should, of necessity, be  
16 expended.

### 17 C. Rehabilitative Services

18 The concept of rehabilitation is very  
19 broad and should include the return to optimal function  
20 of all those who are physically, mentally, socially or  
21 emotionally ill. This goal is often aspired to but  
22 rarely reached owing to the lack of awareness on the  
23 part of health workers which has been engendered by the  
24 chronic lack of facilities, trained personnel and finan-  
25 cial support. Struggling workers have attempted, in  
26 isolated areas, to perform rehabilitative functions  
27 but have had difficult and arduous tasks.

28 All aspects, including vocational,  
29 social, educational rehabilitation should be included.  
30 Improved means of training all phases of rehabilitation







workers should be investigated along with provisions for such training. Incorporating the concept of the economic values in the minds of leaders in the fields of health, business and industry is no small task but should be a key objective of this programme.

#### D. Dental Health

At the present time there exists a shocking standard of dental health in Canada which is directly paralleled by a critical shortage of trained dental personnel. At the present time there are an inadequate number of schools of dentistry which are supplying graduates only to meet the annual loss to the profession, by death, retirements or emigration. Similarly, there are no training programmes of any size for allied para-dental personnel who might assist with less technical dental work and thereby utilize the actual dentist's time more fully and profitably. The role of dental hygienists has never been clarified on the Canadian scene and much more use might be made of this skilled professional person.

Prepaid dental insurance plans are now being investigated. The vast amount of dental ill health makes such plans a very hazardous economic risk unless more detailed study is conducted prior to their inception. Actuarially sound dental insurance plans would only be feasible after field studies of the need followed by detailed data on the usage of such a plan by prospective and potential subscribers. At the present time such information is sadly lacking and might only be gained through factual "pilot" studies in this field.





1 The need for a dental health educational  
2 programme on a national scale seems quite apparent.

3 All factual information, supported by scientific evi-  
4 dence, relating to the outstanding discovery of the  
5 simple addition of minute quantities of fluoride to  
6 drinking water to reduce dental caries should be more  
7 freely distributed to the citizens of Canada. Only  
8 by this means will the public be in a better position  
9 to truly assess the merits of this Public Health measure.

10 As an example of the kind of factual  
11 information which we think should be more widely distri-  
12 buted for the information of the general public, we are  
13 appending hereto a recent scientific article on this  
14 subject which appeared in the Medical Services Journal,  
15 Canada, in October 1961.

16 In the interim period, in communities  
17 where the citizens approve the fluoridation of communal  
18 water supplies, some form of financial assistance might  
19 be made to install the necessary equipment.

20 The research presently going on for  
21 many years now by the Government of Canada would seem  
22 to support the concept that freedom from dental ill  
23 health is enjoyed in those communities with a satisfac-  
24 tory level of fluorides occurring naturally.

25 The absence or presence in insignifi-  
26 cant amounts of natural fluorides in our drinking water  
27 should be viewed as a dietary deficiency resulting in  
28 dental caries much the same as scurvy and ricketts are  
29 judged to be caused by the lack of essential nutrients  
30 in our diets.







1 E. Mental Health

2 Modern concepts of mental health have  
3 radically changed since the day of "psychiatric prisons".  
4 An enlightened concept of restoring many mentally ill  
5 persons to active community life demands a re-focusing  
6 of attention on the patient being treated within his  
7 own neighbourhood and not in a detached institution.  
8 Small psychiatric hospitals with 300-500 beds, depart-  
9 ments within general hospitals, community mental health  
10 clinics, day and night treatment centres, are all  
11 features of the new approach to treating the mentally  
12 ill. Necessary training for all levels of psychiatric  
13 personnel as well as those persons who might conceivably  
14 play a part with patient's having mental illnesses  
15 (Ministers, teachers, social workers, nurses, orderlies,  
16 etc.) is a vital need. Beyond this there is a real need  
17 for education of all citizens in regard to the hopes and  
18 expectations of psychiatric treatment.

19 F. Mental Health Services

20 Inclusion of mental health care under  
21 any prepaid hospital or medical plan, with early diagno-  
22 stic services provided to prevent long standing undiag-  
23 nosed emotional instability. These services should be  
24 correlated with our school system and with our juvenile  
25 courts, they should also include specialized treatment  
26 facilities for juveniles. Provisions of follow-up  
27 treatment and care at the community level of discharged  
28 mental patients with well qualified and adequately  
29 trained personnel advising both patient and families  
30 involved. There should be standardization of all local







1 laws regarding mental illness with the elimination of  
2 antiquated statutes and provision for a more enlightened  
3 approach based on modern psychiatric findings and surveys.  
4 This is especially essential in the case of our elderly  
5 citizens who become senile. Adequate supervised  
6 boarding home care for these patients close to their  
7 homes where they have recovered sufficiently to be  
8 discharged from the psychiatric hospitals or treatment  
9 centres. Many of these patients could be placed in  
10 foster homes in these communities if adequate trained  
11 field staff were provided to supervise such placements.

12 G. Chronic Care Facilities

13 The need for facilities to meet the  
14 medical and nursing problems of those with chronic  
15 illness is perhaps the most pressing in Canada today.  
16 These institutions should care for all those with  
17 protracted illness but whose stay in an acute treatment  
18 hospital is not mandatory. Expensive acute hospital  
19 beds could be relieved with provision for these young  
20 and old patients who, while requiring some treatment,  
21 do not need the full treatment offered in modern acute  
22 hospitals.

23 Beyond this is the problem of boarding  
24 and nursing home care for those members of our growing  
25 aged population. Standards for such homes, supervision  
26 of the care provided, level of care with accompanying  
27 facilities, charges, and many similar problems are all  
28 areas of concern. As our aged population grows in size,  
29 the importance of this problem steadily increases.

30 Provision should also be made for





1 supervised boarding home care for those in our aging  
2 population who are mentally alert but physically unable  
3 to live alone either at their homes or in housekeeping  
4 rooms. The building of such accommodations could be  
5 financed by all levels of government and then turned  
6 over to reliable voluntary groups to be administered  
7 at rates within the reach of those elderly people.







1 H. Training of Health Workers

2 All categories of health personnel should  
3 be well and completely trained in their chosen  
4 particular fields. All technical personnel should  
5 be graduates of approved training schools and certified  
6 as such. Their progressive interests should be  
7 constantly maintained by continued association with  
8 their technical and professional societies and  
9 associations. Provisions of financial support whilst  
10 undertaking training programmes is essential.  
11 Fellowships as under the National Health Grants should  
12 be available for all classes of health workers.  
13 Renewed interest in vocational guidance to direct  
14 good students who are interested and capable into  
15 the many career opportunities. Improved training  
16 facilities and research in better teaching methods  
17 is most important. Closely allied to this is  
18 methodology in training health workers. The general  
19 plan at present is merely to provide factual scientific  
20 material without any effort to make sure the trainee  
21 has any concepts of the more difficult and more  
22 important human side of health and sickness.

23 I. Occupational Health Hazards

24 There is a need for a national occupational  
25 health board established to correlate and recommend  
26 uniform legislative safeguards in health matters in  
27 all occupations of our population. This body could  
28 include representatives from existing Provincial  
29 Compensation Boards, Safety Directors, and so forth.

30 J. Alcoholism





1 This is a growing problem in Canada.  
2 Figures completed to the end of 1959 show at least  
3 217,000 alcoholics in Canada - a rate of 2100  
4 alcoholics for every 100,000 adult population. This  
5 problem has been given careful study by the Alcoholic  
6 Foundation, but it has not been solved. More  
7 support to this Foundation must be given and greater  
8 aid from the government to combat this problem must  
9 be forthcoming.

10 K. Public Health Grants

11 Since the inception of public health grants  
12 in 1948 there have been marked increases in extent  
13 of local health services provided. More facilities  
14 have become available, more personnel were trained  
15 and more new essential programmes have been launched.  
16 In spite of this, many areas of public health require  
17 intensified activity. Principally are areas of  
18 accident prevention, mental health, alcoholism,  
19 maternal and child health, and occupational health.  
20 Additional support through financial aid is needed  
21 to continue the growth spurt fostered by the initial  
22 health grants.

23 That is respectfully submitted, sir.

24 THE CHAIRMAN: Thank you, Mr. Sammon. Have  
25 you anything to add, Mr. Whitehouse?

26 MR. WHITEHOUSE: No, thank you, sir. That  
27 completes our submission.

28 THE CHAIRMAN: In connection with your  
29 recommendation on your health care insurance, as I  
30 understand it, the employees of the Civil Service





1 are covered by a health plan now.

2 MR. WHITEHOUSE: That is correct, sir.

3 THE CHAIRMAN: How is that plan working out?  
4 Is it working out satisfactorily?

5 MR. WHITEHOUSE: I would say it is very  
6 satisfactory, sir. It is a venture almost two  
7 years old now. It is an employer contribution,  
8 50 per cent; we have surgical, medical, diagnostic,  
9 drugs.

10 THE CHAIRMAN: You have the catastrophic  
11 coverage?

12 MR. WHITEHOUSE: Yes, major medical,  
13 \$7,500.00 up to the present time. By an amendment  
14 approved to go into effect July 1st next, that has  
15 been raised to \$10,000.00. Our membership at  
16 present is 200,000 odd members, actually 500,000  
17 people participating including the dependents of  
18 our members, which I should say is 70 per cent of  
19 our people.

20 THE CHAIRMAN: Now, with that background  
21 you say such a plan, talking about a medical care  
22 plan, health care insurance plan, should be  
23 compulsory, the premium shared by the Government  
24 of Canada to participants. Do you contemplate  
25 a plan which will absorb and pass your present plan  
26 out of existence?

27 MR. WHITEHOUSE: We would like to think  
28 that this is a pilot plan. While we are Civil  
29 Servants of the Crown, we are also citizens of  
30 the country, and we think quite a lot of our country,







1 incidentally, and the people that make it so, and  
2 if what we have done is a good criterion for the  
3 rest of the country, then we would have no objection  
4 to throwing our plan into the general one.

5 THE CHAIRMAN: Even though it meant 50 per  
6 cent loss of contribution?

7 MR. WHITEHOUSE: I didn't agree with that,  
8 sir.

9 THE CHAIRMAN: If it had that effect, would  
10 your recommendation carry through to what you --

11 MR. WHITEHOUSE: Let's put it this way.  
12 Actually I haven't any authority to say this, but  
13 judging from the way my people think and speak, I  
14 would think anything within reason, if it is going  
15 to benefit the rest of the population, we would be  
16 prepared to.

17 THE CHAIRMAN: Very fairly said.

18 At the top of page 2 you are speaking of  
19 choice of physicians and you say:

20 "Complete freedom of choice  
21 of one's individual personal  
22 physician should be incorporated  
23 in any such plan".

24 Now, your submission is silent on the basis of payment  
25 for the doctor. Have you any views to express about  
26 that?

27 MR. SAMMON: On the payment to  
28 doctor, sir?

29 THE CHAIRMAN: Yes. You say "the ability  
30 to change from one doctor to another should be





1 incorporated as a personal choice of each patient."

2 You do not refer to the method of paying the  
3 doctor if you have such a plan that you recommend or  
4 one within reasonable limits.

5 MR. SAMMON: I believe the method of paying  
6 the doctor should be on the individual patient basis.

7 THE CHAIRMAN: Are you accepting the fee  
8 for service basis?

9 MR. SAMMON: That is right, sir. We feel  
10 that any deviation from that would go into a plan  
11 of state medicine, which we are very much opposed  
12 to.

13 COMMISSIONER VAN WART: I understand the  
14 present medical care insurance plan in the Civil  
15 Service is quite satisfactory, and do I assume that  
16 what you have mentioned under A takes priority over  
17 the other sections you have mentioned in B to K, or  
18 do you think B to K have a priority over A?

19 MR. SAMMON: I believe A has a priority,  
20 sir.

21 COMMISSIONER STRACHAN: Mr. Chairman and  
22 gentlemen, I wonder if on page 3, excluding the  
23 part of the paragraph at the top, in paragraph 5, at  
24 the bottom full paragraph 5, if you would care  
25 to add there:

26 "The research presently going  
27 on for many years now by the  
28 Government of Canada would seem  
29 to support the concept that  
30 freedom from dental ill health







1 is enjoyed in those communities  
2 with a satisfactory level of  
3 amorphous occurring naturally  
4 or artificially."

5 MR. SAMMON: That is based, sir, on the  
6 report of Brantford and the government survey that  
7 has been carried out. Well, artificially, even  
8 now in other parts of the country, even in three  
9 years they have had the opportunity to make -- for  
10 instance, out in the west they have had an opportunity  
11 to assess it and have just reported that it does  
12 reduce.

13 COMMISSIONER STRACHAN: You have limited  
14 it to occur naturally.

15 MR. SAMMON: Oh, very definitely, or  
16 artificially. We would like to see it in.

17 COMMISSIONER STRACHAN: On the top part  
18 of paragraph 3 you have said:

19 "Prepaid dental insurance  
20 plans are now being investigated."  
21 Is your insurance scheme investigating this at all?

22 MR. SAMMON: Ours is not. We are aware  
23 that some of the provincial dental societies are  
24 investigating on their own.

25 COMMISSIONER STRACHAN: You haven't got  
26 any dental insurance in your plan?

27 MR. SAMMON: No, sir. But we hope to get  
28 it. We have dental surgery, but it is limited to  
29 the surgical aspect.

30 COMMISSIONER STRACHAN: Thank you.





1 COMMISSIONER FIRESTONE: I have no questions  
2 Mr. Chairman, but I would like to congratulate the  
3 Civil Service Association of Canada on a helpful  
4 and constructive submission which has put the welfare  
5 of the citizens of Canada as a whole on the same  
6 basis.

7 MR. WHITEHOUSE: Thank you, sir. I would  
8 like to say that one of our troubles, when we were  
9 successful in getting this plan implemented, was our  
10 retired people. They did not receive the same benefits  
11 as our active people but they had to pay the same  
12 contribution, there was nothing by the employer, and  
13 now there will be full benefit to these retired  
14 people.

15 THE CHAIRMAN: Through your own efforts you  
16 have been successful.

17 MR. WHITEHOUSE: Yes.

18 THE CHAIRMAN: Thank you very much, gentlemen.  
19 We will recess until 10:00 o'clock tomorrow morning.

20  
21 ---Whereupon the Commission adjourned at 4:45 p.m.  
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# ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

OTTAWA

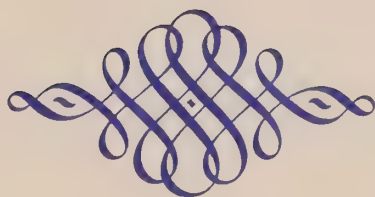
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1  
2 ROYAL COMMISSION ON HEALTH SERVICES

3  
4 Proceedings of the hearing  
5 held in Ottawa, Ontario, on  
6 the 20th day of March, 1962.

7 COMMISSION MEMBERS:

8 Chief Justice EMMETT M. HALL -- Chairman

9 Miss ALICE GIRARD, R.N.

10 Dr. C.L. STRACHAN

11 Dr. ARTHUR F. VAN WART

12 Mr. M. WALLACE McCUTCHEON, Q.C.

13 Prof. O.J. FIRESTONE

14 Dr. DAVID M. BALTZAN

15  
16 COMMISSION COUNSEL:

17 Mr. R.N. Hall, Q.C.

18  
19 COMMISSION SECRETARY:

20 Mr. N. LAFRANCE  
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Ottawa, Ontario,  
Tuesday, 20th  
March, 1962.

---On commencing at 10:00 a.m.

MR. HALL: The next statement is by the  
Canadian Dental Association. I would ask that the  
brief filed by the Canadian Dental Association be  
filed as Exhibit No. 192.

---EXHIBIT NO. 192: Submission of the Canadian  
Dental Association.

MR. HALL: Dr. William Miller of Vancouver,  
the President of the Association will introduce the  
delegation and make a few introductory remarks, Mr.  
Chairman.

SUBMISSION OF THE CANADIAN DENTAL ASSOCIATION

APPEARANCES:

Dr. William Miller

Dr. Remy Langlois

Dr. Don W. Gullett

Dr. William G. McIntosh

Dr. James D. McLean

Dr. Robert M. Grainger

Miss B. Isabel Boyd

DR. MILLER: Mr. Chairman, and members of the  
Commission, as has been indicated my name is William  
Miller of Vancouver, and I am President of the Canadian  
Dental Association. I would like, with your  
permission, to present the other representatives of  
our Association.

On my immediate left is Dr. Remy Langlois  
of Quebec City, a member of the Executive Council. Next





1 is Dr. Don W. Gullett of Toronto, the Secretary of the  
2 Association, and next is Miss B. Isabel Boyd, Director  
3 of the Bureau of Economic Research, Canadian Dental  
4 Association, also of Toronto. Next is Dr. William G.  
5 McIntosh of Toronto, Past President of the Association  
6 and Chairman of the Steering Committee for the preparat-  
7 ion of the brief, and next is Dr. J.D. McLean of Halifax,  
8 Nova Scotia, Dean of the Faculty of Dentistry, Dalhousie  
9 University, Past Chairman of the Council on Dental  
10 Education of the Canadian Dental Association. Next  
11 to him is Dr. Robert M. Grainger of Toronto, Professor  
12 of Biometrics, Director of Burlington Orthodontic  
13 Research Centre, Faculty of Dentistry, University of  
14 Toronto.

15 May I have your permission for Dr. Langlois  
16 to make a few remarks?

17 THE CHAIRMAN: Yes.

18 DR. LANGLOIS: Monsieur le Président, Messieurs  
19 les membres de la commission, Permettez-moi, avant la  
20 présentation de notre bref; d'établir la position du  
21 Canada Français en regard de l'Association Dentaire  
22 Canadienne. Vingt pour cent des membres de l'Association  
23 est de langue Française. Très rares sont les organisat-  
24 ions professionnelles au Canada qui sur le plan national,  
25 peuvent se glorifier de compter parmi leurs membres  
26 autant de Canadiens de langue française. En effet nous  
27 sommes tous sans exception membres de l'Association  
28 Dentaire Canadienne. Notre culture est la contribution  
29 la plus importante que nous apportons à l'étude des  
30 problèmes dentaires et para-dentaires de notre  
Association. Nous sommes fiers de l'unité qui





1 y règne et fiers d'appartenir à l'Association Dentaire  
2 Canadienne. Puisse cet unité de vues et d'opinions être  
3 un exemple à tout notre pays. Ainsi que les autres  
4 provinces qui font partie de notre Association nous  
5 supportons le contenu de bref qui vous sera soumis.

6 THE CHAIRMAN: Merci beaucoup, Monsieur  
7 Langlois.

8 DR. MILLER: The conclusions and  
9 recommendations of the brief will be presented by the  
10 Secretary.

11 MR. HALL: Dr. Gullett, before presenting  
12 the conclusions and recommendations, could you describe  
13 briefly what the Canadian Dental Association is, what  
14 it consists of?

15 DR. GULLETT: Mr. Chairman, the Canadian  
16 Dental Association has some 6,000 members all across  
17 Canada. The ten dental bodies in the ten provinces  
18 are corporate members of the Canadian Dental  
19 Association. The Association has stated objectives,  
20 which I don't think it is necessary to read. They  
21 are on page 2 of the brief. These are contained  
22 in the Federal Statute incorporating the Association.

23 THE CHAIRMAN: Dr. Gullett, in terms of  
24 your membership it might be well for us to note what  
25 Dr. Langlois said, that 20 per cent of your membership  
26 are in the Province of Quebec, which is probably as  
27 many as in any learned society in Canada.

28 DR. GULLETT: We are proud of the fact, Mr.  
29 Chairman, that we have the most truly national  
30 organization that exists in the country. Some people







1 might dispute that, but that is our stand in  
2 connection with the matter.

3 The work of the Association is carried out  
4 through councils and committees. We have a Council  
5 on Education, a Council on Ethics and a Council on  
6 Journalism, and many Committees, making a total of  
7 perhaps some twenty Councils and Committees. We have  
8 two Bureaus, a Bureau of Economic Research, and a  
9 Bureau of Public Information.

10 MR. HALL: Can you tell us, doctor, to what  
11 extent your membership participated in the preparation  
12 of the brief and the formulation of the policies and  
13 recommendations contained therein?

14 DR. GULLETT: The policies of the Association,  
15 as presented in the brief, have been developed over  
16 the last fifteen or twenty years. These policies have  
17 come about by visitations to different countries and  
18 a study of plans which exist in various countries  
19 around the world. The development of policy may  
20 come about by several ways, but usually it is either  
21 developed by one of our Councils or Committees. It  
22 is circulated to our corporate members and the  
23 provinces, and eventually it comes before the Annual  
24 Meeting for adoption.

25 Everything that is proposed in the brief  
26 has been adopted as policy of the Association.

27 MR. HALL: Doctor, will you present then the  
28 conclusions and recommendations of your Association,  
29 as they are set out in your brief, commencing at page  
30 41?





1 DR. GULLETT: As you will observe from our  
2 brief, we have presented a concise statement, followed  
3 by appendices.. As requested, at the very beginning  
4 of the brief we have summarized the main recommendations.  
5 With your permission, Mr. Chairman, I should like to  
6 present the conclusions and recommendations, beginning  
7 at page 41 of the brief. My reason is that the  
8 comments given in this section will be more  
9 explanatory in relationship to the recommendations.

10 There are many who oversimplify the dental  
11 health problem by assuming that an economic barrier  
12 forms the only obstacle to universal dental health.  
13 Unfortunately, the problem is considerably more  
14 complicated. The economic factor cannot be ignored,  
15 but it is not the only or even the most important cause  
16 of poor dental health.

17 (1) Reduce the Need and Raise the Demand for Dental Care.

18 The dental health problem will never be solved  
19 unless the prevalence and incidence of dental disease  
20 are decreased. This is probably the most important  
21 statement that will be made in the brief. This can  
22 be achieved only by more research and by more  
23 preventive measures. . An obvious prerequisite is the  
24 fluoridation of all public water supplies. Intensive  
25 educational programs which inform individuals of the  
26 importance of oral hygiene, good diet and regular dental  
27 care can simultaneously decrease dental need and  
28 increase dental demand. Unless such preventive  
29 services as these are developed and organized, Canada's  
30 dental resources and finances will be consumed in the attempt







1 to restore dental health lost because preventive  
2 measures were not carried out.

3 (ii) Increase the Supply of Dental Services.

4 To accomplish this objective, Canada needs  
5 more dental schools and more dental students to fill  
6 them. Economic barriers to dental education must be  
7 removed. In particular, more students must be  
8 recruited from rural areas and dental practice in rural  
9 areas must be made more attractive. Auxiliary services  
10 must be extended and the number of auxiliaries  
11 increased. The quality of auxiliary services can be  
12 improved by establishing programs of formal education  
13 for assistants and technicians. Hospitals should  
14 establish dental departments and permit dentists to  
15 admit patients to hospital.

16 (iii) Dental Insurance Plan

17 The Canadian Dental Association cannot  
18 recommend a national dental insurance plan at this time.  
19 Emphasis must first be placed on more research, more  
20 prevention and more manpower.

21 If this Commission should recommend the  
22 establishment of a dental insurance plan, however, the  
23 Canadian Dental Association would make the following  
24 suggestions:

25 (a) The dental treatment program should  
26 be preceded by and accompanied with  
27 intensive dental health education  
28 programs.

29 (b) The age groups to be covered by the  
30 treatment program should be determined





1 by initial and annual assessments  
2 of the need of the population and  
3 the personnel and funds available.  
4 If possible, the program should  
5 begin by including all children  
6 from three to six years of age  
7 and should be incremental, extending  
8 annually to children one year older.  
9 In this way, all children up to age  
10 16 would be covered when the program  
11 had been in operation for ten years,  
12 and we give, Mr. Chairman, a simple  
13 chart to illustrate the progress of  
14 the program.

15 (c) Treatment should be provided by  
16 dentists in private practice.

17 (d) Payment for services should be made  
18 on a fee-for-service basis  
19 according to a fee schedule acceptable  
20 to the profession. The method  
21 of payment should recognize the  
22 training, experience and productivity  
23 of the participating dentists.

24 (e) Dentists should be free to participate  
25 or not participate in the plan according  
26 to their own wishes.

27 (f) The right of patients to select their  
28 dentists and conversely the right  
29 of dentists to select their patients  
30 should be protected.





(g) The plan should be administered by provincial non-profit, profession-sponsored dental service corporations which have representative lay as well as professional members on their boards of directors.

(h) The discipline of dentists should be the responsibility of professional disciplinary boards.

(i) No prior authorization should be required for insured services.

(j) Specialist services should be insured only if the patients have been referred to a specialist by a general practitioner.

(k) It would not be possible to include all the services which dentists are capable of providing. For example, between 50 and 75 per cent of the population could benefit from orthodontic treatment. Orthodontic treatment often takes from six months to three years to complete. The scarcity and geographic distribution of orthodontists would necessitate limitation of insured services to the most handicapping cases.

Where services must be curtailed, it is necessary to allocate priority ratings to the various services in order to forestall excessive demands







1 for terminal treatment (e.g. bridges,  
2 dentures, etc.) and in order to extend  
3 to progressively larger numbers of  
4 patients those services which are  
5 essential (e.g. emergency care)  
6 and which contribute most effectively  
7 to the integrity of the teeth and  
8 their supporting structures (e.g.  
9 preventive and maintenance care).  
10 The following order of priority is  
11 recommended for guidance:  
12 - emergency care for the alleviation  
13 of pain and treatment of acute  
14 infections.  
15 - periodic clinical and radiographic  
16 examinations and prophylaxes; topical  
17 application of anti-cariogenic agents;  
18 assessment of dietary and oral hygiene  
19 practices and nutritional status;  
20 supplementary tests (e.g. caries  
21 activity tests).  
22 - care on a planned and continuing  
23 basis to keep the mouth in the best  
24 possible condition; restoration of  
25 carious lesions; elimination of early  
26 periodontal conditions; prevention and  
27 interception of malocclusion.  
28 - provision of terminal treatment,  
29 such as prosthetic appliances, and  
30 correction of established malocclusions.





(1) In financing a dental treatment program, consideration should be given to the possibility of experience-rating municipalities. For example, it is hardly fair that a community which has had the wisdom to fluoridate its water and has thus decreased its caries attack rate by 60 per cent should be taxed for dental insurance at the same rate as a non-fluoridated area. The possibility of placing deterrent taxes on non-essential foods and beverages which definitely increase dental decay should also be investigated.

(m) Direct annual surveys of the dental health of the people should be conducted to determine the direction and development of the program. The success of a dental treatment program cannot be established by the tabulation of the number of operations performed out of an unknown backlog of treatment services.

The goal of the dental profession is to improve the level of dental health until ultimately all Canadians enjoy good dental health. The long held view of the Canadian Dental Association on the method of achieving this ideal was reaffirmed at the Association's annual meeting in 1960.







"In Canada, with the low dentist to population ratio and the high percentage of people suffering from dental disease, it is impossible at present to offer comprehensive dental care to all segments of the population. To initiate a program of restorative services for people of all ages would not result in good dental health for the present population and would actually prevent the realization of this objective for the future generation. Therefore, the first aim of any dental services plan introduced in this country must be to preserve the state of dental health with which the normal child is born. Through a positive program of preventive care for the youngest age groups combined with sound public health measures and intensive dental education for the child and his parents, a generation of Canadians with healthy mouths and the knowledge necessary to maintain that health becomes at last an attainable goal. The extension of coverage to older persons can be made only when it is evident that this can be done at no sacrifice to the care required





1 by the youngest members of the  
2 population."

3 The Canadian Dental Association stands  
4 resolutely opposed to the introduction of a  
5 comprehensive treatment program for people of all  
6 ages.

7 (b) RECOMMENDATIONS

8 (i) Fluoridation

9 The Ontario fluoridation investigating  
10 committee concluded in its 1961 report that "the  
11 fluoridation of municipal water supplies by the  
12 authority of appropriate legislation would not be  
13 a denial of any fundamental or basic civil right  
14 or liberty which the Legislature of Ontario should  
15 protect and preserve". The committee stated

16 "In the past few years, some  
17 municipal councils have taken  
18 the opinions of their voters on  
19 this issue by holding a referendum....

20 We are strongly of the opinion that  
21 this issue should not be decided at  
22 the local level by referendum. Many  
23 aspects of this problem are highly  
24 technical and bristle with apparent  
25 scientific complexities. It bears  
26 no resemblance to such municipal  
27 issues as Sunday sports and  
28 entertainment.....This Committee has  
29 taken almost two years in the  
30 investigation of this problem and





1 during that time has had the  
2 assistance and advice of scientifically  
3 qualified persons.....If the issue  
4 in any municipality were to be  
5 decided by referendum, then most of  
6 the voters would have to make their  
7 individual decisions perhaps upon  
8 inadequate and misleading information."

9 It is recommended that provincial  
10 legislatures make fluoridation of communal water  
11 supplies mandatory through the enactment of legislation  
12 similar to that which exists for the control of water  
13 quality.

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1 139. It is further recommended that  
2 when a province makes fluoridation compulsory, it  
3 should qualify for funds from the federal government  
4 to subsidize the costs of fluoridation. The federal  
5 government could pay 50 per cent of these costs with 25  
6 per cent coming from each of the provincial and municipal  
7 governments.

8 140. It is recommended that the Depart-  
9 ment of National Defence institute communal water fluori-  
10 dation programs in areas under the department's jurisdic-  
11 tion in which military personnel and their dependants  
12 reside.

13 141. It is estimated that the total  
14 annual cost of fluoridation in Canada would be approxi-  
15 mately \$1,500,000.

16 142. Where fluoridation exists, the  
17 average rate of new dental caries can be reduced by 60  
18 per cent. This would result in a tremendous saving in  
19 treatment costs and could as well have a considerable  
20 effect on the dental manpower needs for caries treatment.

21  
22 (iii) Dental Public Health Education  
23 Programs

24 143. Dental disease control is to an  
25 exceptional degree a matter of personal responsibility.  
26 Dental health education is necessary to make people  
27 acutely aware of this. Intensive programs of dental  
28 health education are in varying stages of development  
29 across Canada. Such programs should be organized and  
30 actively promoted in all health regions or units. They





1 should be under the direction of dentists qualified in  
2 public health.

3 144. The programs should be directed  
4 to preschool and young school children. The children  
5 should be examined regularly and referred to private  
6 dentists by notifying parents if treatment is required.  
7 Children should be taught correct methods of oral  
8 hygiene and good food habits. Parents should be educated  
9 in the child's dental health needs at pre-natal and  
10 child health clinics.

11 145. These programs should be financed  
12 by grants from the federal, provincial and local govern-  
13 ments.

14 146. Such programs would greatly  
15 increase the appreciation of dental health and would  
16 greatly reduce, at the patient's own expense, the back-  
17 log of unfilled treatment. People would be encouraged  
18 to seek early care before defects become advanced.  
19 Intensive dental health education offers one of the  
20 major hopes for the eventual control of dental disease.

21 (iii) Dental Research

22 147. For every \$400 spent on dental  
23 treatment only \$1 is spent on research. The amount of  
24 money available for research must be increased substan-  
25 tially if the dental health problem is to be solved.

26 148. The federal granting bodies  
27 which are presently supporting dental research should be  
28 cognizant of the needs for training research personnel,  
29 for appointing more research personnel and for providing  
30 them with sufficient money for their projects.







1 149. The amount of money available for  
2 research should be increased commensurate with the  
3 increased demands of research projects. The amount  
4 necessary will eventually reach approximately \$3,000,000  
5 annually.

6 150. Good liaison should be maintained  
7 between the granting agencies and the Canadian Dental  
8 Association.

9 151. Intensified dental research can  
10 make a real impact on methods of education, practice  
11 and prevention.

12 (iv) Treatment Programs for Public  
13 Assistance Beneficiaries

14 152. Recipients of public assistance  
15 generally cannot afford the dental care they require.  
16 Five provinces already have programs which provide  
17 dental services for some or all people in this category.

18 153. It is recommended that the pro-  
19 vinces institute dental treatment benefits for all bene-  
20 ficiaries of presently operating public assistance pro-  
21 grams.

22 154. It is further recommended that  
23 these programs be administered by the dental profession.  
24 This pattern has proved successful in the provinces of  
25 Alberta, Ontario, British Columbia and Manitoba.

26 155. The estimated total cost of these  
27 programs would be about \$6,000,000 per year.

28 156. The provincial government should  
29 pay a per capita grant on the basis of negotiation with  
30 the provincial dental organization administering the





1 plan.

2 157. These programs would enable this  
3 segment of the population to receive dental care without  
4 economic restrictions.

5 (v). Dental Health Study

6 158. Data on the dental health and  
7 treatment level of Canadians are fragmentary. This  
8 information is vital for planning future dental health  
9 programs. Careful analysis of the reasons for the low  
10 demand for dental care is also necessary to determine  
11 what emphasis should be placed on the various aspects  
12 of dental programs. If there is interest in determining  
13 what treatment levels could be met by specified personnel  
14 and financial resources, a special study is required.

15 159. The Royal Commission on Health  
16 Services, in co-operation with the dental profession,  
17 is urged to undertake a definitive study of dental health  
18 needs and factors influencing demand for dental care.  
19 This study would provide the direction necessary for the  
20 development of future dental programs. The Canadian  
21 Dental Association offers to assist in any way it can in  
22 the planning of such a study.

23 (vi) National Dental Health Index

24 160. Under the charter of the World  
25 Health Organization, member nations are committed to  
26 undertake the gathering and reporting of dental statis-  
27 tics as described in the technical bulletin of that  
28 organization.

29 161. In recognition of WHO recommenda-  
30 tions, the federal government should establish machinery







1 to maintain through annual compilation of dental health  
2 data the dental health index initiated by the Canadian  
3 Dental Association.

4 We take some justifiable pride in the  
5 fact that WHO has adopted the dental health index of  
6 the Canadian Dental Association.

7 (vii) Dental Schools

8 162. Unless the shortage of dental  
9 personnel is to become increasingly acute, immediate  
10 plans must be made to train more dentists and dental  
11 hygienists. To do this more dental schools must be  
12 built.

13 163. Dental schools should be planned  
14 immediately at the University of British Columbia, the  
15 University of Saskatchewan and Laval University.

16 Another dental school should be opened in Ontario. The  
17 Faculty of Dentistry at Dalhousie University should be  
18 expanded. Training facilities for dental hygienists  
19 should be established at the universities of Manitoba  
20 and Montreal and at McGill University as well as at the  
21 four new dental schools recommended.

22 164. The cost of building and expanding  
23 these schools might be approximately \$20,000,000.

24 165. Because this is a matter vital to  
25 national health, the federal government should encourage  
26 the expansion of existing dental schools and the estab-  
27 lishment of new dental schools with facilities for  
28 training dental hygienists by offering to participate in  
29 the capital costs and equipment of these schools.

30 166. Only in this way can sufficient







1 numbers of people be trained to provide dental services  
2 for future generations of Canadians.

3 (viii) More Dental Teachers

4 167. The current shortage of dental  
5 teachers will become much more serious as the necessary  
6 expansion of dental schools occurs. The need is parti-  
7 cularly acute for more full-time career teachers.

8 168. It is recommended that federal  
9 grants to universities be increased in order to permit  
10 dental faculties to improve the ratio of full-time  
11 staff to part-time staff.

12 169. It is recommended that more funds  
13 be made available to support dentists while undertaking  
14 post-graduate education in preparation for careers as  
15 teachers.

16 (ix) Better Salaries for Public Health  
17 Dentists

18 170. In order to attract and hold  
19 competent individuals, health agencies must compete with  
20 the financial returns available in the private practice  
21 of dentistry.

22 171. The average net income of dentists  
23 in general practice exceeds \$10,000 per year. Salaried  
24 dentists, on the other hand, report an average annual  
25 income of only \$7,500.

26 172. In order to give impetus to the  
27 essential improvement and expansion of dental public  
28 health programs, it is recommended that health agencies  
29 adopt dental salary schedules comparable to incomes in  
30 private practice.





(x) More Specialists

173. There is a grave shortage of specialists in dentistry.

174. Dental schools should make provision for training more specialists than they can accommodate now. Those schools not providing graduate programs should be encouraged to do so. More government funds must be made available to the schools for this purpose.

(xi) Recruitment

175. The National Recruitment Committee of the Canadian Dental Association has drafted a workable program for bringing the virtues of careers in dentistry to the attention of more people. Provincial and local recruitment committees are being established in dental organizations throughout the country. Increased numbers of applicants to dental schools in 1961 indicate that recruitment efforts are beginning to produce results. But thorough investigations of the problem and methods of solution are vital if sufficient numbers of high calibre new dental students are to be found.

176. It is recommended that this Royal Commission on Health Services undertake a detailed, thorough study of recruitment to the health professions.

177. Such a study, conducted by the Commission's qualified research staff, might, for instance, show the reasons why students of similar academic interests and achievement do and do not choose particular careers in the health professions and what incentives influence the selection of their careers.







(xii) University Fees

178. The most highly qualified students must be encouraged to enter university. The only criteria for university entrance should be ability and academic achievement. University education is now heavily subsidized, but students still must pay fees which for some may prove prohibitive. There seems to be no logical reason why education should be free for high school students but not for university students.

179. University fees should be continually lowered until at the earliest opportunity they may be removed. As a first step, fees for courses like dentistry which are very expensive and which are educating students for a profession experiencing a critical personnel shortage should be reduced so that they are comparable with fees for other university courses.

180. With the removal of this economic barrier to higher education, more students would be encouraged to apply for university admission.

181. For dentistry alone, the removal of fees at the present capacity of the dental schools would cost \$700,000 annually.

182. The federal government should increase its annual per capita grants sufficiently to permit the universities to reduce fees.

183. The result of this measure would be an increase in both the quantity and quality of university students.





(xiii) Dental Student Loan Fund

184. Even if all university fees were removed, many young people would find it difficult to enter dentistry because they could not afford their living expenses while at university. The economic burden is particularly great for students from out of town and for those living away from home. Also it is often financially difficult for dentists to undertake graduate or post-graduate courses.

185. It is recommended that a revolving loan fund be established for undergraduate and post-graduate dental students.

186. Students could borrow up to \$1,000 each year. The loan would be repaid after university. For example, if a student borrowed \$500 in each dental year, he would repay the \$2,000 at \$500 a year for four years following graduation. During this period the loan would be interest free. Students would be recommended for the loans by their dental schools. Selection would be made by a national committee composed of representatives of the dental schools, the profession and the government. Preference would be given to (a) students from rural areas; (b) students living away from home; (c) graduate and post-graduate students.





187. The fund should begin with \$100,000.

Later it may be necessary to raise it to \$500,000.

The Canadian Dental Association will contribute one half of the initial amount and requests that the federal government provide the other \$50,000.

188. It is expected that such a fund would increase the number of dental students, particularly those from rural areas.

(xiv) Expenses of Post-Graduate Education

189. In the interest of improving dental services for the people of Canada, dentists should be given every possible inducement to pursue professional education beyond the attainment of a university degree and a licence to practise.

190. Attaining additional qualifications means not just the expense of the education itself but also an actual loss of income while away from practice, with overhead expenses continuing regardless of the dentist's absence. These expenses understandably deter many dentists from attending short refresher courses and other types of post-graduate education.

191. It is recommended that federal and provincial income tax regulations be amended to permit tax relief for dentists who attend training courses under auspices of universities or recognized dental associations.

(xv) Students from Rural Areas

192. While students from small communities tend to settle in communities of similar size after graduation, it is difficult to attract graduates from







1 large cities to small centres. More students from rural  
2 areas should be enrolled in dental schools.

3 193. As long as the uneven urban - rural  
4 distribution of dentists continues, dental schools  
5 should give preference to applicants from rural areas,  
6 all other factors being equal.

7 194. If by this measure more students from rural  
8 areas are enrolled, it is to be expected that in the  
9 future more graduates would establish practices in  
10 these areas.

11 (xvi) Placement of Dentists

12 195. It is particularly difficult to attract  
13 dentists to practice in rural municipalities.

14 196. Aid should be provided to encourage more  
15 dentists to settle in municipalities without resident  
16 dentists.

17 197. This aid should consist of (a) the provision  
18 of an equipped dental office preferably in the  
19 community hospital; (b) the guarantee of a minimum  
20 income in exchange for dental services for children.  
21 Adults would be cared for on a fee-for-service basis.

22 198. The provincial department of health in  
23 cooperation with the dental profession could process  
24 applications from municipalities for dentists,  
25 determining in particular whether the municipality  
26 has sufficient population to support a resident dentist  
27 and avoiding overlapping of dental service areas.

28 If these conditions were satisfied, the province could  
29 share equally with the municipality the costs  
30 involved.





199. More dentists would thus be encouraged to settle in areas where dental services are not now available.

(xvii) Rural and Remote Areas

200. In certain areas, the population is too scattered to warrant a resident dentist. Provision of dental services in these areas creates a special problem.

201. The provincial governments should engage full-time travelling dentists to serve these areas.

202. These dentists could be provided with automobiles and transportable dental equipment. They would receive salaries and would provide dental services for children in the areas in which they travel. After regular office hours, they would be allowed to treat adults on a fee-for-service basis.

203. These projects should be eligible for support from national health grants.

204. This plan should increase the dental care available to residents of remote areas.

(xviii) Extension of Auxiliary Services

205. In order to increase dental productivity the scope of services rendered by auxiliaries must be increased considerably.

206. It is recommended that pilot studies and operational research be supported so that the best methods of using auxiliary personnel both in private practice and in public health services may be determined. These studies must be conducted in dental schools.







1 207. A national survey committee composed of  
2 members of all universities with dental schools should  
3 be set up to coordinate these research projects.

4 208. At the present time, government grants are  
5 not available for clinical research projects of this  
6 type. It is urged that a government grant of \$50,000  
7 be provided to initiate them.

8 209. The findings of these studies should give  
9 direction to the effective integration of dental  
10 auxiliaries into the dental health team.

11 (xix) Education for Dental Technicians  
12 and Assistants

---

13 210. At the present time, there are no formal  
14 programs for training dental assistants and technicians.  
15 More well trained assistants are needed. Rather than  
16 increase the relative technician / dentists ratio,  
17 the standard of education and level of training  
18 of dental technicians must be elevated to enable  
19 them to cope with the increasing complexity of their  
20 duties.

21 211. It is recommended that the training of  
22 future dental assistants and technicians be carried out  
23 using clinical facilities of university dental schools.  
24 The training of present assistants and technicians  
25 should be reinforced by planned training courses.

26 212. It is recommended that the federal-provincial  
27 partnership in the field of financial aid for  
28 vocational training be extended to facilities for  
29 training dental assistants and technicians.

30 (xx) Hospital Dental Departments





213. Dental departments should be established in all public hospitals in areas where dental personnel are available to provide both in-patient and out-patient services.

214. The by-laws under which such departments are created should permit the provision of professional dental services to patients in accordance with the concepts of modern scientific dentistry, giving due regard and cognizance to the professional judgment and skill of the dentist or dentists who have been duly appointed to the professional staff of the hospital.

(xxi) Admittance to Hospitals

215. Dentists appointed to hospital staffs should be able to fulfill their professional role and assume maximum responsibility for their services unencumbered by restrictive regulatory provisions.

216. Provincial public hospital acts or regulations should be amended to permit dentists appointed to hospital staffs to admit patients to hospitals.

217. The patient admitted to hospital for dental service should be given a physical examination by a member of the medical staff.

218. The dentist would then be able to admit patients to hospital on the same basis as patients are admitted for other generally elective treatments.

(xxii) Outpatient Dental Clinics

219. As the hospital is increasingly becoming a centre for health care services, out-patient dental clinics should be established in public general hospitals





1 especially to assist in meeting the needs of marginal  
2 income groups.

3 220. Dentists who have been accorded hospital  
4 staff privileges should provide service on a rotational  
5 basis and charges made to patients should be comparable  
6 to those assessed for other out-patient services.

7 Facilities, auxiliary personnel and equipment should  
8 be adequate to enable the participating dentists to  
9 render the maximum of high quality dental care.

10 (xxiii) Cleft Palate Centres

11 221. Centres for treatment of cleft palate cases  
12 should be established in children's hospitals and in  
13 general hospitals where adequate paediatric and  
14 associated services are available.

15 222. Physicians, dentists, surgeons, oral surgeons,  
16 orthodontists, psychiatrists, speech therapists, social  
17 workers and allied services all contribute to the  
18 habilitation of the child born with cleft palate and/or  
19 hare-lip defects. Because much is yet to be learned  
20 about these potentially crippling problems, research  
21 programs should be a concomitant of any treatment  
22 services provided.

23 THE CHAIRMAN: Thank you very much, Dr.  
24 Gullett.

25 MR. HALL: Mr. Chairman Dr. Gullett and  
26 his colleagues are prepared to enlarge upon any area  
27 or answer any questions which the members of the  
28 Commission may have.

29 COMMISSIONER STRACHAN: Mr. Chairman may I  
30 presume your prerogative and right and pleasure of







1 congratulating my confreres and all those associated  
2 in the preparation of the brief before us. It is  
3 indeed a record of Canadian Dentistry 1962.

4 During the past weeks this Commission has  
5 heard much about the high cost of medical and dental  
6 care and drugs. I think you have stated the  
7 dental case very definitely: that the public have  
8 it within their own personal and individual grasp  
9 to reduce the cost of future dental care first by  
10 the fluoridation of all communal water supplies.  
11 Secondly by recognizing that the 100 lbs. of sugar  
12 consumed per person per year is an important factor  
13 in promoting tooth decay and that decay can be  
14 considerably reduced by properly cleaning the teeth  
15 after eating or having concentrated sweets and by  
16 eliminating sweet foods between meals. May I  
17 say we see daily in our practices the ravages of  
18 certain soft drinks in particular. Thirdly by  
19 utilization of a balanced diet, particularly during  
20 the time teeth are developing.

21 Moreover as you have also inferred the  
22 high cost of dentistry is brought about by the delay  
23 and neglect of the individual and that high cost  
24 to the patient does not necessarily mean greater or  
25 excessive remuneration for the dentist because he has  
26 only two hands and so much time to make a living  
27 for himself and his dependents and no dentist has  
28 yet become a millionaire by his labours alone, even  
29 though he spends his life in the personal service  
30 of his fellow man.





1           These remarks lead me to my first question  
2       which pertains to the first recommendation of the  
3       Canadian Dental Association.   This brief gives  
4       statistical information and makes recommendations  
5       respecting fluoridation and you suggest that each  
6       year's delay will cost the public millions of dollars  
7       for extra and needless dental care.

8           What in your opinion is the main obstacle  
9       in forwarding this public health measure?

10          DR. GULLETT:   The Canadian Dental Association  
11       adopted a policy of approving the fluoridation of  
12       communal water supplies at their annual meeting in  
13       the year 1952.   This was only done after there had  
14       been some thirty years of research upon this subject.

15          We do not believe there is any other public  
16       health measure that has had the amount of research  
17       that this one has had.   The Association initially  
18       determined, and they have held fast to the policy,  
19       that in promoting fluoridation we would only make  
20       proven scientific statements.

21          The facts are, and I think the greatest  
22       obstacle is, simply stated, that the statement of  
23       scientific statements are no match for the un-  
24       warranted or groundless statements which hinge on  
25       fear tactics when it comes to votes and referendums.

26          We do not think, as stated in our brief,  
27       or as we have quoted from the Ontario Investigating  
28       Committee, that subjects of a scientific nature  
29       like fluoridation are subjects which should be  
30       considered by referendum.







1 THE CHAIRMAN: Dr. Gullett in answering  
2 further questions, if you wish to remain seated...

3 DR. GULLETT: Thank you.

4 COMMISSIONER STRACHAN: Page 41, paragraph  
5 130 you emphasized the removal of economic bars  
6 would not greatly improve dental health.

7 THE CHAIRMAN: Dr. Strachan before you  
8 leave fluoridation, there have been as we know  
9 certain areas in which fluoridation is in effect  
10 and in which studies have been made. Would it be  
11 possible, do you think there would be any value  
12 in allaying this fear that you say exists if a  
13 pilot project might be initiated in which the known  
14 opponents are invited to participated?

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DR. GULLETT: Well, there would be certain inherent difficulties in a project of that nature, Mr. Chairman. It must be remembered that this is a long-term project. These experiments in communities have been carried out in 10, 12, 14-year bases. Now, the difficulty of trying to carry out a project of that nature with a group who are opposed in the first place I think may be extremely difficult on account of the length of time that is involved in the project.

THE CHAIRMAN: Have you any views, or perhaps even more than that, any evidence that the known opponents are a sort of professional group of opponents who may be benefiting themselves financially by being opponents?

DR. GULLETT: Well, we know considerable on the point. On the other hand, we would hesitate to make a statement, because I think the Commission would be in their rights to ask us to furnish proof of what we say. There are leaders who are in the business of opposing, and it is rather strange who these people are when we trace them down, not only on this one but on the preceding one. We know that the literature of these people is not sold by the copy as most publications but it is sold by the pound and distributed in great quantities.

But I want to say this, that the people who naturally listen are quite sincere in the fear that evolves in their minds because of the tactics that are used by anti people, and it is a rather pitiful situation,





1 we think, that this should go on. We look upon the  
2 allowing of a child to grow up with loss of teeth  
3 through caries when it can be prevented as being almost  
4 of a criminal nature to allow this to go on.

5 Admittedly, as a profession we are  
6 biased on this point.

7 THE CHAIRMAN: Have you found that  
8 there is any organized opposition, that is any opposition  
9 to fluoridation areas in the community at any one time,  
10 or does this opposition seem to move from one community  
11 to another as a vote when a plebiscite is being taken?

12 DR. GULLETT: It doesn't arise in the  
13 community itself. It is an organized effort that goes  
14 to work in the community; that is the difficulty.

15 COMMISSIONER STRACHAN: You have  
16 mentioned that economic bars would not greatly improve  
17 dental health. Would you care to enlarge on that matter?

18 DR. GULLETT: Well, of course, economics  
19 are a factor in anything we do in this life; we have to  
20 pay. Our contention is that the money question is not  
21 anywhere near the factor that it is supposed to be, at  
22 least from the proposals which are made by lay organiza-  
23 tions, and so on. We just simply do not believe that  
24 this is the main factor.

25 Now, we have a few reasons for it. In  
26 the first place, dental service is an elective service,  
27 people can put it off, and the result is that too much  
28 of it is put off and it becomes serious and becomes  
29 expensive in the end result. Extensive surveys have  
30 been conducted on this question, and we make some report







1 in our brief in respect to this.

2 There is a table, Table V-5 or 6 in  
3 this report which says that in large surveys education  
4 is a factor in improving dental health and not economics.  
5 By saying that I mean it is a much greater factor,  
6 education is.

7 Then again we have dental services to  
8 people in this group, the old-age pensioner, the mother's  
9 allowance people and these other groups. Now, these  
10 services, there is no payment on the part of the indivi-  
11 dual at all. We haven't ever been able to get utilization  
12 in any of these groups up to 50% of the group. In one  
13 of these plans up to two years' operations in the  
14 children's group, these are the children under mother's  
15 allowance, only 19% utilized the service.

16 Of course, in these plans there is no  
17 education of the group whatsoever; it is simply to come  
18 and get. If the intention is - and we think this is  
19 important as to what the intention is - if the intention  
20 is to improve dental health of the nation or any specific  
21 group within the population, then education is a much  
22 more important factor than economics. There is no  
23 question in our minds in respect to this point.

24 COMMISSIONER STRACHAN: Mentioning  
25 health education leads me to an expression I had in  
26 mind. On page 19, paragraph 64, you state:

27 "Intensive dental health education  
28 should precede treatment services in  
29 a dental health program".

30 And then in the appendix you state that





1 the Ontario plan is unique in that the public health  
2 dentists do not engage in any treatment services, and  
3 you refer to Red Cross grants.

4 With such statements in mind, what  
5 initial steps should be taken in respect to dental  
6 health education?

7 DR. GULLETT: Well, the bible part of  
8 any plan for the improvement of dental health is  
9 certainly education, as we have just said. In order to  
10 achieve the effectiveness of this education you must  
11 have individuals trained to carry out the program, and  
12 there is no question in our minds that the greatest  
13 initial need is for trained individuals to carry out  
14 the program.

15 Now, this necessitates the training of  
16 dentists in public health and the establishment of  
17 dentists trained in public health as directors of the  
18 program in each health program or area. We have about  
19 95 out of our membership who are today trained, they  
20 are graduate dentists, and they are trained in public  
21 health, and a number of these are today in positions  
22 in health units as directors of public health.

23 They carry out their program, but  
24 there is a great obstacle in this business of filling  
25 these positions. We have always had many more positions  
26 than we could get personnel to fill them, and the  
27 obstacle is simply this: that an enthusiastic dentist  
28 for this type of activity, to ask him to give up prac-  
29 tice, take a year graduate training and after he has  
30 done all this then he is asked to accept a position at







1 a salary one-half or two-thirds of what he was earning  
2 in private practice.

3 Now, being human, it is almost too  
4 much to expect a man to do this. The man who does it  
5 certainly has to have a lot of enthusiasm, and perhaps  
6 his wife and family don't go along very well with this  
7 reduction in income. Before we can make much progress  
8 in connection with this matter there has certainly to  
9 be some adjustment between the salaried man and the  
10 man in private practice.

11 COMMISSIONER STRACHAN: Thank you, Dr.  
12 Gullett.

13 You have made much reference to research,  
14 and you state that as far back as 1920 dentists formed  
15 the Canadian Dental Research Foundation and contributed  
16 \$20,000, and then on page 36, paragraph 114, you state:

17 "Encouragement and financial support  
18 by the profession at large have been  
19 major factors in this development".

20 To what do you refer? What has been  
21 the record of the profession in recent years in respect  
22 to this?

23 DR. GULLETT: Dr. McIntosh, please?

24 DR. MCINTOSH: Mr. Chairman, in answer  
25 to Dr. Strachan's question, the \$20,000 that was referred  
26 to as originally being donated by the profession under  
27 the terms of this Research Foundation came from private  
28 dentists as a memorial gift for the dentists who lost  
29 their lives during the First World War, and the interest  
30 from this money was mainly used for several years in





1 helping to disseminate the results of dental research,  
2 the scientific knowledge. Then more recently in one  
3 area, at least in the University of Toronto, a research  
4 division was established there, and it was established  
5 primarily on the basis of funds which were raised again  
6 from the dental profession. Both individual dentists  
7 contributed and from efforts made to raise some funds  
8 from business and private companies. Something in the  
9 amount of \$300,000 was collected in this way and this  
10 was enough to get this research division established at  
11 the Faculty of Dentistry at the University of Toronto.

12 We are still using funds from this  
13 sum, and, of course, in the interval funds have also  
14 been made available to allow the research effort to  
15 grow, both from the trained personnel and the research  
16 projects they are undertaking.

17 COMMISSIONER STRACHAN: Then you refer  
18 to the research budget of the C.D.A. being \$10,000 for  
19 this year. What would be the total over recent years?

20 DR. McINTOSH: Are you referring, Dr.  
21 Strachan, to just the C.D.A. budget?

22 COMMISSIONER STRACHAN: Yes, I am.

23 DR. McINTOSH: Well, the figures are  
24 in the brief. Without looking up the brief, the C.D.A.  
25 contributed \$10,000 a year for several years. This  
26 money is being used in three main ways. Its prime  
27 purpose is to stimulate and assist young men who want  
28 to increase their training in research procedures, and  
29 so it is used in the form of studentships which assist  
30 financially in securing this training.







1 Some of it is also used in setting up  
2 a travel branch so that research investigators can  
3 move from one area to another for consultation.

4 Some of it is also being used for the  
5 dissemination of scientific knowledge that is being  
6 accumulated as a result of research projects.

7 COMMISSIONER STRACHAN: Thank you.  
8 You answered the next question I had in mind. The  
9 studentships are part of that research?

10 DR. McINTOSH: Yes, sir, they are, a  
11 very important part of it. They were established back  
12 in 1944, and each year since then the Canadian Dental  
13 Association has been contributing in this direction.

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1                   COMMISSIONER STRACHAN: You stated that  
2 great advances in dental research have occurred in  
3 recent years. You mention the possible future  
4 figure of \$3,000,000 annually being required for  
5 dental research. Can you enlighten us with respect  
6 to the possibilities in the future?

7                   DR. McINTOSH: Well sir, the brief points  
8 out, and Dr. Gullett has already mentioned two or  
9 three times, that the application of new preventive  
10 measures offer the greatest promise in reducing  
11 the incidence and prevalence of dental disease, and  
12 we believe that more research, particularly in the  
13 basic sciences, is necessary in order to develop  
14 these new preventive measures. We have had an  
15 example already of the results of this kind of  
16 research in the mention that was made of the benefits  
17 of communal water fluoridation and we know that in  
18 areas where this has been put into effect we have  
19 this reduction of dental caries by as much as 60 per  
20 cent. Now, dental caries, as you are well aware,  
21 is only one aspect of dental disease. Peridontal  
22 disease, malocclusion, the cleft palate, hair lip,  
23 abnormalities that have already been mentioned, all  
24 these things are equally important, we believe, in  
25 producing poor oral and general health, and eventual  
26 tooth loss.

27                   Up to the present time preventive measures  
28 for aspects of dental disease other than caries are  
29 in their very, very early stages of development. We  
30 believe that much additional knowledge will be





1 required before true preventive measures can be  
2 applied to any of these conditions, and therefore  
3 in regard to future possibilities of research I  
4 would like to suggest that these possibilities would  
5 encompass first of all the need to recruit and train  
6 many additional research workers. Another point  
7 would be that the completion of these research projects  
8 in all phases of dental science, and we would like  
9 to emphasize the basic sciences, because here we  
10 believe we need the additional knowledge in the  
11 biological processes involved in health and disease  
12 to get at true prevention. Then of course from  
13 this new knowledge we would need to develop and apply  
14 new preventive procedures that would be directed not  
15 just against dental caries, but against all types  
16 of dental disease.

17 We believe that as a result of the  
18 application of new preventive measures we would be  
19 able to come closer to a complete dental care  
20 program for the people of Canada.

21 There is probably one additional point, and  
22 that is that as a result of this new research we  
23 would anticipate methods of teaching and methods of  
24 practice would also change.

25 So that this \$3,000,000 figure that has  
26 been mentioned is intended to apply to all of the  
27 procedures that would be involved, the recruitment,  
28 the training, the research itself, the application,  
29 and the methods, and so on.

30 COMMISSIONER STRACHAN: You make reference







1 to teaching and regarding your recommendation No. 8,  
2 what are the difficulties in securing fulltime  
3 teachers in dental schools?

4 DR. McLEAN: I suppose there are two basic  
5 areas of difficulty. That is the financial problem,  
6 and also the matter of finding personnel.

7 Referring first to the financial problems,  
8 the salaries of the full time teachers are now  
9 inadequate. At best, the university teachers, who  
10 must be, should be leaders in the particular area,  
11 the particular subjects which they are teaching, must  
12 have a costly advanced education in these areas, and  
13 at the present moment they are exceedingly fortunate  
14 if the salaries which they receive on completion of  
15 their period of study approach those of their  
16 confreres in general practice, let alone the  
17 specialists practising in these areas. So the first  
18 thing is competition with the private practitioner  
19 as to the economic position of the teacher versus  
20 the private practitioner. It is a very great  
21 barrier.

22 Then again, in connection with the cost  
23 involved, the cost of advanced education enters into  
24 it. With relatively little or no financial  
25 assistance to people who wish to become career  
26 teachers, they find themselves in a very difficult  
27 situation. Many of the graduating students are  
28 married or about to be married. They are reaching  
29 an age when most of their friends are married, and  
30 assume financial obligations. The prospect of three





1 or more years in graduate training to prepare themselves  
2 for teaching careers, during which time they will have  
3 no income and considerable expense, is a great  
4 deterrent, when the alternative is that they may go  
5 immediately into private practice and an early  
6 opportunity of establishing practices which will  
7 provide them with an income at least equal, and  
8 probably better than that which they will obtain at  
9 the end of their graduate period.

10 The next point is with respect to the  
11 pool from which teachers can be drawn by the  
12 universities. It is practically non-existent I might  
13 say. Again, in the first place full time teaching  
14 careers in dentistry, the opportunities were  
15 exceedingly limited until recent years, the past ten  
16 years or so, and therefore most of the practitioners,  
17 the dentists of the generation or past generations,  
18 didn't really consider career teaching opportunities,  
19 or didn't prepare themselves, and were not orientated  
20 in this direction. Therefore a great deal of  
21 recruitment and persuasion has to be done, to  
22 persuade these people to leave the area of practising,  
23 and go into teaching as a career.

24 The second point is with the increase of  
25 the number of schools which may take place in the not  
26 too distant future. There is a great competition  
27 resulting between the universities for the same  
28 small group of individuals who can be attracted into  
29 teaching. The very shortage of dentists also  
30 contributes to this problem, so that from a university







1 administrator's point of view our first problem is  
2 to find money in the university budget which is  
3 always difficult, to find sufficient money to attract  
4 people from other areas of dentistry which are more  
5 rewarding financially. In many instances it is  
6 necessary to provide money for the graduate training  
7 of prospective teachers.

8 Thus, the real need is for assistance in the  
9 training program, and assistance to the universities  
10 to provide adequate salaries so that people will be  
11 attracted into a career in teaching.

12 COMMISSIONER STRACHAN: Where would you  
13 prefer these prospective teachers come from? From  
14 the present under-graduate body, or from men who have  
15 been in practice for a period of time, or from part-  
16 time personnel?

17 DR. McLEAN: I don't think it is an either  
18 or proposition entirely, because it depends on the  
19 area in which they are going to teach.

20 If they are going to be in the areas of  
21 the fundamental sciences, it might be acceptable to  
22 have them come directly from schools. In the clinical  
23 field, however, it is desirable that they should  
24 have had some experience in private practice, and  
25 again that they might have had some experience in  
26 teaching, so we might say we would like to have them  
27 from all three areas.

28 COMMISSIONER BALTZAN: What is the relation  
29 between the full-time men and the part-time men of  
30 your teaching staff?







1 DR. McLEAN: Do you mean as to the ratio?

2 COMMISSIONER BALTZAN: Yes?

3 DR. McLEAN: The majority in all the  
4 schools, I think it would be safe to say that the  
5 majority of the teachers are on a part-time basis.  
6 The ratio I think recommended is something like 60  
7 per cent full time and 30 per cent part-time. We  
8 are lucky if the reverse obtains. In most of the  
9 schools it is less than 30 per cent at the moment  
10 of full time teachers.

11 COMMISSIONER STRACHAN: Speaking of students,  
12 and referring to recommendation No. 12, what effect would  
13 you expect in relieving educational expenses for  
14 dental schools?

15 DR. McLEAN: At the present time the proportion  
16 of students in dentistry who come from families of  
17 below average income, that is the average income of  
18 all Canadians, is quite small, and thus it would  
19 appear that the profession of dentistry, or the study  
20 of dentistry at least, is somewhat restricted to those  
21 students, men and women who come from families of  
22 medium or higher income levels within our society,  
23 and the dental profession believes that there should  
24 not be an economic barrier to students who have the  
25 ability and the desire for careers in dentistry.  
26 We believe that substantially more assistance ought  
27 to be made available to dentistry students, and that  
28 it should be provided on a national basis. That is  
29 to say that the graduate should be free to select  
30 the area of Canada in which they may choose to stay.





1 Again, whether it is private practice, or teaching,  
2 or whatever it may be, and that the only restriction  
3 as to the area in which they locate if subsidies  
4 are provided to them should be that they must remain  
5 within Canada as a whole, not necessarily within  
6 a designated province or area of a province, city,  
7 town, or whatever it may be, but incentives actually  
8 to practice in a given area should not be coupled  
9 with student aid, but if it is necessary to provide  
10 subsidies to attract people into rural communities  
11 we think that aid, there should be, perhaps, providing  
12 offices in a community hospital, and by the provision  
13 of guaranteed income, in exchange for which the  
14 dentists might provide services for children, the  
15 adults paying their own expenses.

16 We would like to reiterate, or I would like  
17 to reiterate, that there should not be an economic  
18 barrier to higher education, and particularly to  
19 dental education, which is more costly than many  
20 other areas of higher education. We would like to  
21 see this removed as early as possible so that there  
22 would be then a larger pool of students from which  
23 the schools could draw potentially good teachers.

24 COMMISSIONER STRACHAN: Arising from that,  
25 there are two other questions. The first thing,  
26 recommendations 15 and 16, were references made to  
27 the uneven urban-rural distribution of dentists.  
28 What is the main reason for the lack of dental services  
29 in rural areas?

30 DR. GULLETT: Strictly speaking, I think you







1 would have to put first the question of supply and  
2 demand. However, it is not quite that easy, because  
3 there are other factors which come into this  
4 situation. Even if we had a surplus of personnel,  
5 the problem would be eased, but much of it would  
6 still remain. There are other reasons for ther  
7 being lack of dental services in rural areas besides  
8 the lack of personnel. Municipalities which did  
9 at one time support dentists no longer will support  
10 a dentist.





1 One of the big factors is the customs  
2 or habits of people. Good roads, improved methods of  
3 transportation, people just simply like to have a reason  
4 for travelling 25 miles to a larger centre in order to  
5 have their services performed. We have had a lot of  
6 experiences with this because we have had excellent men  
7 who have had the desire to get out of what they call the  
8 rat race of the big city and go out to a small territory.

9 The people who should support the  
10 dentist and perhaps who put on the most pressure to get  
11 a dentist in this small area never darken the door of  
12 his office; they drive off to a larger community.

13 It might enlighten the discussion a  
14 little bit and we have no end of illustrations but while  
15 the hearings were on in Edmonton, we had a man practising  
16 in the city who tried, he left Edmonton and went to  
17 Fort Saskatchewan for two or three years.

18 Unfortunately he just was not making  
19 a living in spite of the shortage of dentists.

20 THE CHAIRMAN: The patients in Fort  
21 Saskatchewan are rather inhibited.

22 DR. GULLETT: This man moved back into  
23 Edmonton and he found himself with more patients in  
24 Edmonton from Fort Saskatchewan than he had ever had in  
25 Fort Saskatchewan. He felt this was a humorous situa-  
26 tion and he questioned these people who did not even  
27 recognize he had been in Fort Saskatchewan. He would  
28 ask them if they had gone to the dentist in Fort Saskat-  
29 chewan and they would come back with such remarks as  
30 "Any fellow who would go to Fort Saskatchewan to practise





1 I would not go to him". Here was the same man in  
2 Edmonton.

3 Now, these are human factors that miti-  
4 gate against. You see the position; a man goes into a  
5 small area, the people have motor cars, the people who  
6 are obviously the best patients he could not have  
7 because they go off 25 miles away. The dentist is then  
8 left with people who obviously have not a mode of trans-  
9 portation and less people pay for dental services.

10 Now, there are other illustrations but  
11 I think you can see there are further problems besides  
12 simply the case of supply and demand.

13 THE CHAIRMAN: May it not be just a  
14 matter of accepting what is becoming a different way of  
15 life in that we won't see as many professional people in  
16 the smaller communities anywhere?

17 DR. GULLETT: I am afraid that is true.

18 THE CHAIRMAN: Perhaps we should not be  
19 trying to break a barrier that we must accept and sort  
20 of build to meet what is a differing situation.

21 DR. GULLETT: That is right. We have  
22 a good many illustrations, I could give a whole list of  
23 stories similar to the Edmonton story and some have been  
24 very sad experiences. We have had excellent men from  
25 large municipalities ---

26 THE CHAIRMAN: The public does not want  
27 dentists in these smaller areas?

28 DR. GULLETT: That is right.

29 THE CHAIRMAN: Or doctors or lawyers?

30 DR. GULLETT: That is right, the same







1 applies.

2 COMMISSIONER STRACHAN: This would be  
3 an appropriate time to make reference to paragraph 86  
4 on page 27 where you say there were 600 applicants for  
5 the 338 vacancies in the 1961-62 freshmen classes and  
6 that there were 320 finally enrolled. Does this mean  
7 that it was impossible to get 18 more students out of  
8 the 262 who have made application and were not received?

9 DR. McLEAN: It should be appreciated  
10 not everyone of these meets the qualifications to the  
11 University or, at least, to the particular dental  
12 schools. There is some overlapping in applications,  
13 that is, students will apply to more than one school;  
14 this is not as great as we had expected it might be.  
15 Then, of course, it may be there could be a surplus in  
16 one area who would not be readily transferrable to  
17 another area.

18 I think it is safe to say the students  
19 in any given area in proximity to the dental schools  
20 are pretty well accepted.

21 COMMISSIONER STRACHAN: It does seem  
22 unfortunate 18 vacancies still exist in the dental  
23 schools this year.

24 DR. McLEAN: Yes.

25 THE CHAIRMAN: With that you are recom  
26 mending additional schools; now, is there an apparent  
27 discrepancy there?

28 DR. McLEAN: Well, again you get the  
29 question of need and demand but moreover there was some  
30 thing like a 77% increase in the number of applicants





1 last year, in the current session of the schools. I  
2 can only speak for one school at the moment but it looks  
3 as though we will have about 100% increase this year.  
4 What we are suggesting is the number of applicants has  
5 increased, the number of qualified applicants, we trust.

6 Over and above that there is still  
7 need to encourage by providing student subsidies and  
8 other means of encouragement into dentistry. The recom-  
9 mendation for more schools is to provide a more adequate  
10 supply of dentists.

11 We must also look to recruitment, there  
12 must be a great deal of activity there and I believe  
13 that is improving but it is not improving as rapidly as  
14 we would like.

15 COMMISSIONER STRACHAN: What are the  
16 basic requirements for the school?

17 DR. McLEAN: In general, the basic  
18 requirements for admission to dental school is one year  
19 for university beyond the senior matriculation or, in  
20 effect, two years of university during which time  
21 certain specified courses are set out or mentioned by  
22 the various schools, chemistry, physics, biology and  
23 there are some elective subjects.

24 COMMISSIONER STRACHAN: I was thinking  
25 more of the percentage standing.

26 DR. McLEAN: This again does vary a  
27 little bit from one region to another and actually  
28 between universities because percentages are different  
29 in that some universities may tend to give higher marks  
30 than others.







1 In general it has been found that  
2 students who have less than 60% to 65% average in their  
3 pre-school studies are less likely to be successful in  
4 dental schools.

5 COMMISSIONER STRACHAN: Somewhere it is  
6 stated that ability and academic standing are considera-  
7 tions; where does "ability" come in?

8 DR. McLEAN: Ability is largely reflected  
9 in academic standing. At the moment a good deal of  
10 study has been given to this but it has been the experience  
11 of universities that their academic standing is the best  
12 predictor we have at the moment, their academic standing  
13 in the pre-school years particularly in the sciences.

14 On the other hand, the Canadian Dental  
15 Association has been encouraging a study over the last  
16 several years to look at other areas to determine if  
17 there are some other particulars we can use to determine  
18 the best method of selecting students. Academic  
19 standing is still the best predictor the schools have.

20 COMMISSIONER STRACHAN: Regarding  
21 recommendation 13, I would like to be modest about this  
22 but I certainly have pride in such a suggestion coming  
23 from the Canadian Dental Association regarding the  
24 revolving loan fund. Would you care to comment on this?

25 DR. GULLETT: We know that there are  
26 students that have financial difficulty during their  
27 course and this is designed to help the student who runs  
28 into difficulties.

29 Primarily we are greatly interested in  
30 the boy who is trying to get a university education and





1 comes from the low income family group.

2 On the other hand, we simply do not  
3 believe in handing money out on a free basis and this  
4 loan is designed that the boy is helped and after  
5 graduation he pays back into the fund.

6 Now, we think that this creates a  
7 spirit which should exist in that this man is helped  
8 through his course and when he pays back into the fund  
9 he is helping another student in similar circumstances  
10 which he went through.

11 We like the principle which is behind  
12 this type of thing and we think it is important that  
13 the individual student takes on the responsibility  
14 himself for repayment of the money which he receives.

15 As stated here, it would be interest-free  
16 up to the time involved in his course after graduation.

17 THE CHAIRMAN: Your answer and the  
18 paragraph in the brief presupposes that everyone will  
19 graduate; what happens to those who fall along the way?

20 DR. GULLETT: We realize that there  
21 will be a certain percentage of this money lost, perhaps  
22 on sympathetic grounds, if for no other reason.

23 We do not have many students who drop  
24 out of the course for physical reasons because they are  
25 examined physically when they come into the course. We  
26 do have unfortunate circumstances occur and very likely  
27 there would be a loss.

28 THE CHAIRMAN: Perhaps Dr. McLean could  
29 give us a figure on attrition due to failure and so forth  
30 of those entering the course.







1 DR. McLEAN: There is a table here  
2 showing the attrition.

3 DR. GULLETT: There is a table giving  
4 11% between the first and second years.

5 DR. McLEAN: May I point out that one  
6 of the advantages which is only one on the pre-profes-  
7 sional program is that a good deal of screening is done  
8 for us at that level so our attrition level is reduced  
9 over what it would be if we admitted directly.

10 The biggest drop comes between the  
11 first and second years.

12 May I just add one word to what Dr.  
13 Gullett has said? I think there may be a misunderstan-  
14 ding between this and the proposal for reduction of  
15 fees and student bursaries in addition to loan funds.

16 I assume that these loan funds would  
17 only cover a portion of the costs just as a bursary  
18 would only cover a portion of the total cost to the  
19 student and they are not incompatible in that sense.

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1 COMMISSIONER STRACHAN: Dr. McLean there  
2 are still other important areas to be considered.  
3 I am thinking of dental services, hospital and  
4 auxiliaries. What should be the relationship of  
5 dental service to hospitals?

6 DR. GULLETT: We believe, Mr. Chairman,  
7 that dental service is an essential health service  
8 and as such should form an integral part of the  
9 hospital service.

10 The health of the mouth has definite  
11 systematic relationship and the patient in hospital  
12 should have the benefit of dental services which  
13 may be a factor, and an important factor in  
14 relationship to the recovery of the patient.

15 There are also certain services, dental  
16 services, which are best performed in hospital. It  
17 is in the best interest of the patient to have these  
18 services performed in hospital. Dental services,  
19 in our opinion, should be instituted in hospital  
20 as a Hospital Department in the same manner as  
21 other departments of the hospital.

22 Now we are not too sure that the National  
23 Hospital Plan is any assistance in achieving this  
24 objective because as we have seen in these hearings  
25 in different places, finances are becoming very  
26 important in connection with hospital operation and we  
27 question if the finances are not going to work against  
28 the achieving of such objective as we propose here.

29 COMMISSIONER STRACHAN: As a matter of  
30 interest, how many of the fourteen hospitals with





1 dental service approved by the C.D.A. have rehabilitat-  
2 ion teams as detailed on top of page 22?

3 DR. GULLETT: I am not at all sure that  
4 any of them have rehabilitation teams per se as they  
5 should be. That is not one of the points in  
6 accreditation of a hospital at the present time.

7 COMMISSIONER STRACHAN: But to a degree  
8 it is carried on?

9 DR. GULLETT: That is right. There are  
10 certain hospitals. The Sick Childrens Hospital in  
11 Toronto carries out a team idea which is excellent.

12 COMMISSIONER STRACHAN: If we might  
13 consider auxiliaries for a moment. On page 26,  
14 paragraph 81:

15 "In addition, educational  
16 programs must be established and  
17 expanded so that dental auxiliaries  
18 can be trained thoroughly to  
19 render a broader scope of  
20 service than is possible now."

21 Now on page 30 paragraph 99 you state:

22 "Properly qualified and  
23 recognized dental auxiliaries  
24 could be trained to render a  
25 broader scope of service than  
26 that presently recommended."

27 On page 32 paragraph 103 you say that  
28 auxiliaries should be trained to render a far broader  
29 scope of duties than currently feasible. On page  
30 33 paragraph 108:







1 "The only location in  
2 dentistry comparable to the public  
3 general hospital is the patients'  
4 clinics of the faculties of  
5 dentistry where a relatively large  
6 volume of patients receives the  
7 widest variety of professional  
8 attention."

9 In what capacity could auxiliaries be  
10 trained and how are they trained?

11 DR. McINTOSH: In answer , Mr. Chairman,  
12 to the first part of that question I think it is  
13 important to realize that we are talking about three  
14 types of dental auxiliaries: technicians, the  
15 assistant and the hygienist.

16 Very briefly, the technician fabricates  
17 dental appliances according to a prescription that  
18 is provided by the dentist. The assistant acts as  
19 a chair side assistant, secretary, receptionist,  
20 bookkeeper, light housekeeper. That is the type  
21 of duty in the dental office. Both of these groups of  
22 auxiliaries at the present time have no formal  
23 training.

24 The hygienist, the third type of auxiliary  
25 does require a formal course of training that at  
26 the present time consists of two year program at  
27 a dental school, following which the hygienist is  
28 licensed to practice preventive and educational  
29 services under the supervision or direction of a  
30 dentist.





1 At the present time these preventive and  
2 educational services mainly include such things as  
3 cleaning teeth, topical application of fluoride  
4 solution, taking and developing radiographs, giving  
5 instructions in home care procedures designed to  
6 promote oral health, and this general area of  
7 activity.

8 Our experience has indicated that the  
9 efficient use of the services of these three groups of  
10 auxiliaries can greatly increase the total volume  
11 of dental service provided without any reduction  
12 in the quality of the service. In order to provide  
13 more dental service to the public, therefore, it  
14 is suggested that the scope of the services provided  
15 by these auxiliaries might be considerably expanded  
16 and we make the suggestion that pilot studies be  
17 established to determine the best method of using  
18 the auxiliary personnel both in private practice and  
19 in a public health service.

20 I would like to emphasize that in these  
21 pilot studies, in fact in the application of the  
22 services of these auxiliaries, we feel there are  
23 two very important principles that should be adhered  
24 to and the first of these is that services that  
25 the auxiliaries will do, the data rendered must not  
26 include any of those operations requiring scientific  
27 knowledge of the fully qualified dentist. We can  
28 go on and expand this and say there are many  
29 technical parts of operations and many technical  
30 operations that we believe they could well be trained





1 to do.

2 The second important principle is that  
3 the licensed dentist must retain the full  
4 responsibility for the welfare of the patient. So  
5 that in answer to your first question, it is our  
6 recommendation that in view of the potential of  
7 increasing the quantity of good service to the public  
8 that the services of these three groups of  
9 auxiliaries might be expanded but they be done so on  
10 the basis of pilot studies which would be set up  
11 to show us how best these services could be  
12 expanded.

13 COMMISSIONER STRACHAN: Do you suggest then  
14 that the pilot study is an immediate need in the  
15 development of children's health?

16 DR. McINTOSH: Yes sir.

17 COMMISSIONER STRACHAN: Then on page 33,  
18 paragraph 107, you state that "no formal training program  
19 for dental assistants and technicians exists in Canada."  
20 And then I repeat the paragraph I read before, you  
21 say that the only location in dentistry comparable  
22 to the public general hospital is the patients'  
23 clinics of the faculties of dentistry where a  
24 relatively large volume of patients receives the  
25 widest variety of professional attention. Are  
26 there difficulties in accomplishing this within  
27 the university? Could these difficulties be  
28 overcome in the foreseeable future?

29 DR. McLEAN: We believe that the program  
30 should be integrated with the teaching of the dental







1 student in so far as possible. It may be that the  
2 program could be established -- this is for your  
3 technician and your dental assistants -- could be  
4 implemented by a vocational school but making use of  
5 the clinical facilities of the university or the  
6 clinical aspects of the training programs and that  
7 in this way the university facilities might be used  
8 if the university were not prepared to take on the  
9 full responsibility of the program.

10 In other words, the vocational school,  
11 certainly with the cooperation of the dental profession,  
12 might provide the core and some of the teaching being  
13 done in the clinical programs of the universities.

14 COMMISSIONER STRACHAN: Had any of the  
15 universities been approached on that basis?

16 DR. McLEAN: I am not sure. There is  
17 consideration in our own university on this subject  
18 at the moment on a very tentative basis. I cannot  
19 speak for the others.

20 COMMISSIONER STRACHAN: Perhaps I would  
21 like to comment on your recommendations 5 and 11 Dr.  
22 Gullett; your suggestions about the further studies  
23 this Commission should do.

24 DR. GULLETT: The first is the dental health  
25 study are you referring to?

26 COMMISSIONER STRACHANA: Yes, that is right.  
27 Recommendation 5.

28 DR. GULLETT: I would like Miss Boyd to speak  
29 on this point.

30 MISS BOYD: We must emphasize that any





1 information we have on dental treatment needs at  
2 the present time are very fragmentary and before any  
3 program could be instituted, we would have to have  
4 a great deal more information than now exists on  
5 this subject.

6 In particular, we would be interested in  
7 determining to what extent the various factors relate  
8 to the fact people do not get enough dental care at  
9 the present time in order that programs could  
10 emphasize education, etc. in proper perspective.  
11 We feel that the Royal Commission could, possibly  
12 with the facilities it has available, institute such  
13 a study.

14 DR. GULLETT: The other recommendation I  
15 think Dr. Grainger, in respect to index, could make  
16 a reply.

17 DR. GRAINGER: I beg your pardon, I was  
18 talking for a moment with Dr. Jobin.

19 DR. GULLETT: The National Dental Health  
20 index.

21 COMMISSIONER STRACHAN: Yes, and  
22 recommendation No. 11 Dr. Grainger.

23 DR. GRAINGER: My experience with it was,  
24 inasmuch as it was developed in Ontario, in  
25 connection with the dental public health education  
26 program. Traditionally a dental program has been  
27 inaugurated with the idea we must get in there and  
28 do something about this treatment and it would  
29 generally be of a palliative nature, doing emergency  
30 work and the report of the program would generally







1 include a big tabulation on a number of this type  
2 of operation and that type of operation done in the  
3 community and yet there would be no indication that  
4 the result of this money spent has actually met  
5 conditions or did anything so that future conditions  
6 would be better, so this is quite an innovation.  
7 We think in the public health field you should stop  
8 tabulating how much you have been doing. As it were,  
9 how big the cloud of dust is but after the program  
10 has been in effect to actually go and look and see if  
11 conditions are better say from the point of view of  
12 having these educational programs on an experimental  
13 basis and from the point of view of being able to gauge  
14 them and direct their methods; small sampling surveys  
15 were conducted of the conditions of these areas so that  
16 they can say at the end of each year we improved such and  
17 such on what we were doing; we did not improve that.  
18 They could direct their program.

19 This has now been put into a larger manual  
20 for use in any part of the country and there has  
21 been agreement on the types of criteria used so that  
22 data collected in the east coast is comparable to  
23 that on the west coast and we can easily see how  
24 dental health is going in the country so under the  
25 name "Dental Health Index" it is just merely a logical  
26 way of taking a look and seeing if we are getting  
27 better by directly observing the children which you  
28 are trying to treat.  
29  
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1 COMMISSIONER STRACHAN: Mr. Chairman,

2 I feel it would be unfortunate if this Commission did  
3 not have some comment on the establishment of a dental  
4 insurance plan, and undoubtedly it would bear some  
5 consideration of the British scheme, and I know of no  
6 one better qualified to give this Commission information  
7 on this particular subject than Dr. Gullett.

8 DR. GULLETT: It is a rather large  
9 order, and having studied the British scheme and made  
10 almost annual visits and studied it for 15 years, it  
11 is a little difficult to be precise.

12 The British scheme is a most comprehen-  
13 sive health scheme that any country has in the world.  
14 The inclusion of dental services for the whole population  
15 is counted I think on the highest authority today to  
16 have been one of the grave errors to have been made in  
17 the introduction of the scheme.

18 The sad part of these things is that  
19 once something of that nature is done, on a political  
20 basis it cannot be withdrawn. I think it important  
21 that the financial situation created by such a move be  
22 made known; the figures are available in the annual  
23 report in the Ministry of Health, and the truest picture  
24 is in the first couple of years of operation of the  
25 scheme, before any deterrents were brought into the  
26 scheme - I think everybody realizes there were quite a  
27 lot of deterrents put into the British scheme for all  
28 the services - but previous to that.

29 The scheme was introduced in 1948, and  
30 for the year 1948-49 the dental services under that







1 scheme cost 88.2% of what the general medical practitioner  
2 services cost. In the next year, 1949-50, the dental  
3 services cost 101.5%, as compared to the general medical  
4 practitioner services.

5 I don't think that these things are  
6 realized; dentistry is not a cheap service. We hear  
7 the statements made so often that dental services are  
8 somewhat of an appendage to medical services and are  
9 just brought in as a sort of supplementary benefit.

10 You are not dealing with a supplementary  
11 benefit. If you realize that, roughly speaking, the  
12 dental services in the British scheme and the general  
13 medical practitioner services, before the deterrents,  
14 cost practically the same thing.

15 There is another thing. There are  
16 18,000 medical practitioners, and there has never been  
17 over 10,000 dentists practising. These figures are  
18 significant to show you what this means from an economic  
19 standpoint. They have a quantity of dental services  
20 under the British scheme. The quality of the service  
21 is somewhat different. It is admitted by all authorities,  
22 including government authorities, that the quality of  
23 dental services has dropped materially since the intro-  
24 duction of the scheme.

25 It is simple to understand, because it  
26 is done on a mass basis. There was neither the personnel  
27 nor the facilities nor anything else in order to take  
28 care of the job that was thrown on the profession in  
29 Great Britain.

30 THE CHAIRMAN: Have you got a figure of







1 the ratio in Canada, physicians to dentists? You said  
2 it was 18 to 10 in England.

3 DR. GULLETT: Yes. The ratio is approxi-  
4 mately one dentist to 3,000 population. Perhaps Dr.  
5 Van Wart can give the figures.

6 I think these are cardinal points.  
7 We, of course, would be very fearful of any such things  
8 happening in Canada. We feel that our quality, which  
9 has been striven - we have striven to establish, - would  
10 drop by any such scheme of that nature.

11 COMMISSIONER STRACHAN: Do you feel,  
12 Dr. Gullett, that quality or standard of dental services  
13 can be maintained or remuneration may affect personal  
14 integrity in practice?

15 DR. GULLETT: Well, if I could have  
16 the liberty I would like to expand a little on that  
17 point.

18 We have endeavoured to study practically  
19 all of the schemes which are in operation in the various  
20 countries. This has been going on over a 15-year period.  
21 As some of the members of the Commission know, I have  
22 spent time in these countries and surveyed the schemes.

23 Personally, the saddest thing I ever  
24 hope to see is to see the moral fibre go out of the  
25 dental profession, because so much depends on it, and  
26 this happens in these countries in many instances under  
27 compulsory plans.

28 Once the esprit de corps is built up  
29 and lost in the rank and file of the profession it  
30 cannot be recovered, and it is a most regrettable





1 situation.

2 Of course, we all realize that if a  
3 compulsory tax-supported scheme in health services is  
4 introduced, public funds are utilized, there has to be  
5 a budget; that is realized. But when the money starts  
6 to run short there are just two alternatives - and  
7 this applies to all the services under the schemes -  
8 there are just two alternatives: either cut the pay of  
9 the practitioner or cut the services, one or the other,  
10 and these things repeatedly happen in these various  
11 countries.

12 In conversation with the better health  
13 economists, both employed by the governments in these  
14 countries and elsewhere, they say to me quite frankly  
15 that health services as a commodity cannot be suitably  
16 marketed under monopolistic control.

17 Alternatively, they say that health  
18 services are much better purveyed under market control.  
19 You see, the practitioner places service first and econo-  
20 mics second.

21 Now, in spite of all that is said today  
22 about the professions, we don't claim we have 100%  
23 perfect men in our profession, but we do know that over  
24 90% of our men practise on this basis. In these  
25 countries, when the professional man finds himself  
26 reversed and he finds that the finance is the controlling  
27 factor in the type of service he renders, he then does  
28 what is human, he throws up his hands and says "Well,  
29 it is useless".

30 Last year at Helsinki one of the finest







1 ethical men that I know came up to me and said: "Well,  
2 it is wonderful to come here and have the social time  
3 with all you men, but as far as learning anything new,  
4 it is useless because I can't use it in my practice  
5 after I return home".

6 Now, I was very impressed with that  
7 statement, because that same man 15 years ago said to  
8 me that it didn't matter what rules the government  
9 brought in, what legislation government brought in,  
10 that he would carry on his practice just the same as  
11 he always did.

12 He couldn't do it. These things are  
13 not conducive to improving health services. We say that  
14 whatever plan is developed there must be complete co-opera-  
15 tion of the profession, in administration as well as in  
16 everything else that pertains to it.

17 We heard yesterday in this room that  
18 health services should be made a public utility. It is  
19 the intangibles that are in the practice of health  
20 services that make health services better. The emphasis  
21 today is on systems of how to operate services.

22 Well, they can develop a system easy  
23 enough, but the system is not the important thing as  
24 far as improving the health of the people of a nation  
25 is concerned. Sure, the system will set up repair  
26 factories for the human body, but they will not create  
27 necessarily better health services and better health  
28 for the people.

29 There seems to be an idea that by some  
30 government some place passing a piece of legislation





1 people are going to be healthier. It is not true. We  
2 have ample proof in no end of countries that that does  
3 not happen.

4 Personally, I think one of the best  
5 studies that could be made would be a comparative study  
6 over the past 15 years of countries with compulsory  
7 health schemes and countries which do not have compulsory  
8 health schemes and let's see where the progress is being  
9 made in health services, and I have no doubt whatsoever  
10 what the result of that study would be.

11 Perhaps I haven't answered the question,  
12 but I have got quite a bit off my chest in respect to  
13 the whole proposition.

14 COMMISSIONER STRACHAN: I don't think,  
15 Mr. Chairman, I have any more questions.

16 COMMISSIONER VAN WART: Mr. Chairman,  
17 I have a few questions to ask as regards registration of  
18 dentists, and the first is in reference to Table XXI-1.  
19 In this table you say that many of the provinces do not  
20 accept graduates from schools outside the United States  
21 and Canada and some do accept.

22 And also in the first line, that most  
23 of them require Canadian citizenship before they are  
24 accepted. Do you screen these men who come to you very  
25 carefully by other means besides what is stated here in  
26 the table?







1 DR. GULLETT: Yes, I think first it should be  
2 said that we have a tremendous variation in dental  
3 education in the different countries of the world.  
4 A much greater variation than occurs for example in  
5 medicine, and I know it is bad enough in medicine,  
6 but ours is much worse.

7 Now, the system that we have is that these  
8 men who apply, many of them come from countries, or  
9 from schools which couldn't be recognized under any  
10 circumstances. The training is not comparable to  
11 the training in Canada. These men are, through a  
12 system we have set up, they are screened by the  
13 universities in their basic science training. If  
14 they are successful, and the examination is not  
15 entirely one whether they make 50 marks or not, it is  
16 to find out what training they have had. If they  
17 are successful, they are admitted to a dental school.  
18 The dental school decides where in the course it is  
19 proper to admit them. We have a great number of men  
20 who are now practising in this country who have gone  
21 through this process. The basis of the whole thing  
22 is that these people are asked to meet the standards  
23 which the students in Canada have to meet for  
24 graduation.

25 COMMISSIONER VAN WART: The graduate dentists  
26 of foreign schools. How do you screen them?

27 DR. GULLETT: They are screened the same way.  
28 Now, as shown here through experience there are  
29 certain men who are accepted for license examination  
30 without going through this process. For instance,







1 the man who has a degree from Great Britain is  
2 admitted for license without any further screening.

3 COMMISSIONER VAN WART: Your Continental  
4 dentists. After you accept them, or they pass  
5 your examinations, do you require them to have a year  
6 to accustom themselves to your language and customs?

7 DR. GULLETT: That is right, and language is  
8 one of the great difficulties in even examining some  
9 of these people.

10 COMMISSIONER VAN WART: Turning to the  
11 table on xxi-2, I notice that your candidates  
12 require an enabling certificate from the province,  
13 and then they take their federal examination, and  
14 that entitles them to practice in any province in  
15 Canada. Well now, do the provinces ---

16 DR. GULLETT: They receive a certificate  
17 of the National Board, which they can register in any  
18 province in Canada.

19 COMMISSIONER VAN WART: Yes, that is correct.  
20 If they go to a province other than where they  
21 received their enabling certificate, does that  
22 province require any further examination?

23 DR. GULLETT: Between the ten Provincial  
24 Registrars there is an understanding that if anyone  
25 of them signs an enabling certificate it will be  
26 accepted by the other provinces.

27 COMMISSIONER VAN WART: After a man has  
28 successfully passed his federal examination, does  
29 he have to take an examination, or can he be made to  
30 take an examination, in basic sciences in any province?





1 DR. GULLETT: No, no other examination.

2 COMMISSIONER VAN WART: If that is a foreign  
3 applicant, is there any restrictions placed on him?

4 DR. GULLETT: There is some difficulty  
5 between the National Board and the foreign applicant.  
6 If the foreign applicant graduates from a school, he  
7 is admitted to the school and graduates from the  
8 school, then he can take the National Board  
9 examination.

10 COMMISSIONER VAN WART: But if he is a graduate  
11 of a foreign school he is able to obtain an enabling  
12 certificate in one province, and then passes his  
13 examinations. There is no further restriction on  
14 him when he goes to another province?

15 DR. GULLETT: Unfortunately that is a problem  
16 that is not quite clear at the moment. We hope that  
17 it will be shortly.

18 COMMISSIONER VAN WART: In what way is  
19 it not clear?

20 DR. GULLETT: Well, the regulations governing  
21 the National Board does not accept foreign applicants  
22 directly at the present time.

23 COMMISSIONER VAN WART: Even if he has  
24 passed his Federal examination?

25 DR. GULLETT: No, the Federal examination  
26 is the National Board examination, you see.

27 COMMISSIONER VAN WART: But if he obtains  
28 an enabling certificate from one province, hasn't  
29 he the right to write the examination then?

30 DR. GULLETT: Yes, that is a thing we hope







1 to correct. At the present time the provincial  
2 registrar will not issue him with an enabling  
3 certificate, but that matter needs to be corrected,  
4 and we hope to correct it shortly.

5 COMMISSIONER VAN WART: You spoke of  
6 shortages of instructors and teachers. Is there not  
7 a place, or field, for a foreign dentist to come into  
8 universities?

9 DR. GULLETT: Yes, there are several of them  
10 who have been brought to Canada particularly from  
11 Great Britain, who are now on the staff at our  
12 universities. These are usually higher degree men.

13 COMMISSIONER VAN WART: Does the same apply  
14 to the continent?

15 DR. GULLETT: Not so much from the  
16 Continent. Dental education on the Continent is a  
17 very mixed breed of cat.

18 COMMISSIONER BALTZAN: Dr. Gullett and  
19 gentlemen, this has been one of the most instructive  
20 and informative discussions I have been privileged  
21 to listen to. I would like to direct one question  
22 to the Dean.

23 THE CHAIRMAN: I wouldn't like these  
24 gentlemen to think that one question is going to  
25 exhaust it.

26 COMMISSIONER BALTZAN: No, the others  
27 have covered what I had in mind to ask them.

28 Have you given any thought to the question  
29 of accelerating, or shortening the course in  
30 dentistry for various reasons, without affecting the





1 quality?

2 DR. McLEAN: Yes, I can say that we have.

3 On numerous occasions the deans in our annual meetings  
4 have given consideration to this subject, to the  
5 matter of telescoping if possible. Theoretically it  
6 might be possible to some degree, but there are certain  
7 precautions, and we haven't seen our way around it at  
8 the moment. As you have suggested sir, we should be  
9 certain that we retain the standards of education in  
10 the first place. One of the first hurdles to be  
11 covered would be the necessity for an increase in the  
12 number of qualified teachers in order to accelerate the  
13 program, the teaching program of each of the full time  
14 teachers in particular, and also the part time is already  
15 over crowded. I daresay that the teaching load, the  
16 actual student contact to the teachers in the dental  
17 faculty is heavier than in any other areas in the  
18 University at the moment, so we would have to find more  
19 staff, and the finances to support them. The cost to  
20 the students would enter into it, because at the  
21 moment almost 100 per cent of the students rely on  
22 summer employment. They now have about three months,  
23 and it is a longer term I might add than the regular  
24 arts and science program in the University. If we  
25 were to go on an eleven or twelve months basis in the  
26 universities this would create perhaps an impossible  
27 barrier for some students, and there are already  
28 sufficient economic barriers, we feel, in that  
29 direction. We don't see our way clearly through that  
30 one. The course of studies is already expanding, and





1 in indeed in recent years we were very reluctant to  
2 add additional years to the teaching program, but  
3 there has been some expansion to the academic year  
4 already. I think most of the schools are now on at  
5 least a nine months basis. We might theoretically  
6 add two months in the year, which would reduce the  
7 total time by six months at best.

8 We are concerned too that the intellectual  
9 development of the student is highly important, and I  
10 think if one studies the pattern of learning, one finds  
11 that there are periods when there is a sudden rise,  
12 and then plateaus which run throughout the period of  
13 the undergraduate curriculum. One must be careful  
14 not to so over crowd the program that he does not have  
15 time to consolidate his thinking. Moreover, the  
16 students have so little time, and practically no time  
17 during the current academic year for outside interests,  
18 and we don't want our people to be too restricted in  
19 their viewpoints. Outside reading, for example, is  
20 limited to vacation periods. The intellectual  
21 development might be restricted.

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1 As I suggest, we might add two months  
2 to the program, and by streamlining, I think we would  
3 have to allow a month's vacation there, not only for  
4 the schools, for their clean-up program and preparing  
5 for the next session. So we would save two months a  
6 year for three years, and a great saving is not going  
7 to be achieved in the long run, but some.

8 The final problem is the integration  
9 with the rest of the University. All of the dental  
10 schools now depend to a greater or a lesser degree  
11 upon the medical faculty of the country to do at least  
12 a part of the basic science teaching. To streamline  
13 the program without the co-operation, at least of the  
14 medical faculty, would be probably impossible in the  
15 first year, and probably in the second year.

16 These are some of the problems which  
17 face us.

18 COMMISSIONER BALTZAN: Your length of  
19 the course now is what, six years?

20 DR. McLEAN: Four years following the  
21 two pre-professional years.

22 COMMISSIONER BALTZAN: Actually then,  
23 six years in preparation?

24 DR. McLEAN: Yes.

25 COMMISSIONER BALTZAN: Am I right that  
26 you have been advocating also an internship year, or  
27 are some schools advocating that?

28 DR. McLEAN: Not as a formal requirement  
29 for licensing examinations. We think it is advisable  
30 to provide internships as training programs for certain





1 students, but we don't visualize this as a requirement  
2 for licensing at the moment.

3 THE CHAIRMAN: Gentlemen, at this  
4 point we are going to recess until 2 o'clock. If you  
5 will be good enough to return then there are certain  
6 other areas we are going to explore at that time.

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8 --- Luncheon adjournment.  
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1 --- On resuming at 2 p.m.

2 THE CHAIRMAN: Mr. Hall, are you ready  
3 to proceed with the Canadian Association of Medical  
4 Students and Interns?

5 MR. HALL: Yes, Mr. Chairman.

6 THE CHAIRMAN: We made this change to  
7 accommodate the Commission due to the fact that Dr.  
8 Firestone is detained for 15 or 20 minutes so rather  
9 than hold everything up we will go on with this brief.  
10 We appreciate your courtesy in standing by for the  
11 moment.

12 SUBMISSION OF THE CANADIAN ASSOCIATION OF  
13 MEDICAL STUDENTS AND INTERNS.

14 Appearances: Cliff Lauriault  
15 Wm. MacQuade  
16 Gerald Rosenthal  
17 W.B. Kingston

18 MR. HALL: I suggest the brief of the  
19 Canadian Association of Medical Students and Interns  
20 be filed as Exhibit 193.

21 --- EXHIBIT NO. 193: Submission of the Canadian Associa-  
22 tion of Medical Students and Interns.

23 MR. HALL: The President of the Associa-  
24 tion, Mr. William Kingston, will introduce the members  
25 of the delegation.

26 MR. KINGSTON: Mr. Chairman and members  
27 of the Commission, we would like to express our pleasure  
28 at having the opportunity to appear here before you  
29 today to present the opinions of medical students and  
30 interns in Canada.





1 With me, on my right, is Mr. Gerald  
2 Rosenthal, Public Relations Officer of the CAMSI/ACEMI  
3 and fourth-year student at Dalhousie.

4 On his righthand is Mr. William  
5 MacQuade, Treasurer of the National Executive and also  
6 a fourth-year Dalhousie medical student.

7 On the extreme right, Mr. Cliff  
8 Lauriault, the President of the fourth-year class at  
9 the University of Ottawa who has kindly consented to  
10 join us in presenting a portion of the brief en francais.

11 MR. HALL: Mr. Kingston, could you just  
12 briefly describe your organization and tell the Commis-  
13 sion its composition?

14 MR. KINGSTON: CAMSI/ACEMI was formed  
15 at a meeting of the Student Christian Movement in  
16 Winnipeg, Manitoba in January 1937 by a number of  
17 medical students who felt there was a purpose for an  
18 organization with the aims to promote the exchange of  
19 ideas among medical students and interns, to promote  
20 the investigation and attack common problems at the  
21 national level and to help prepare the members for a  
22 national medical citizenship.

23 The group comprises 98% of Canadian  
24 medical students, about the same proportion of interns,  
25 both in Canada and the United States as well as a small  
26 number of residents both in Canada and the United  
27 States as well as Great Britain, who remain members of  
28 the organization while studying.

29 The National Executive is proposed or  
30 nominated by a host school annually and then they are







1 elected by the annual assembly of the organization  
2 comprising local CAMSI/ACEMI officers at the annual  
3 meeting held each year at a different medical school.

4 MR. HALL: Could you tell us what  
5 part, if any, your general membership plays in the  
6 formation of this brief and the recommendations  
7 contained in it?

8 MR. KINGSTON: The incoming executive  
9 at an annual meeting in Quebec City in November was  
10 requested to consider the possibilities of presenting  
11 a brief to this Commission. They contacted the Commis-  
12 sion with that in mind and received a tentative appoint-  
13 ment. They then formulated a proposed outline of the  
14 brief which was taken to nine of the medical schools in  
15 Canada in person by myself in January of this year.

16 Then, impressions, ideas and opinions  
17 were solicited from these schools. Committees of  
18 students at Dalhousie University in league with their  
19 advisors, the Deans of Medicine in Canada, were instruc-  
20 ted to prepare the actual material in the brief and  
21 there was a final presentation of the brief to all  
22 medical schools in Canada during the past two weeks.

23 Of the 12 medical schools, 9 schools  
24 accept the brief as being representative of their  
25 opinions. The University of Toronto Medical School  
26 rejects the brief in toto.

27 THE CHAIRMAN: For what reason?

28 MR. KINGSTON: We were given several  
29 reasons but I would not like to elaborate those at the  
30 present time. I can if you wish.







1 THE CHAIRMAN: If you want to file them  
2 with us.

3 MR. KINGSTON: The brief was considered  
4 by 26 members representing the students of Toronto and  
5 they informed us that they disagree with three major  
6 sections of the brief; that the Ontario Medical Associa-  
7 tion is violently opposed to the presentation of this  
8 brief at the present time and that their Dean is opposed  
9 to the brief as presented. Those would comprise the  
10 major reasons given.

11 McGill University medical students  
12 recognize the brief as being representative with the  
13 exception of paragraphs 10 and 38 regarding the source  
14 of money for financial assistance given the undergra-  
15 duate students. They feel that this money should arise  
16 from sources independent of the Federal Government until  
17 such time as it has means to do so adequately.

18 The University of Montreal medical  
19 students favoured the brief with the exception of the  
20 views expressed in the preamble, particularly those of  
21 the Canadian Medical Association and the specific propo-  
22 sal of a system of aiding medical undergraduate students.

23 All agree that given more time we would  
24 prefer to file a more detailed and factual document.

25 MR. HALL: Could you perhaps describe  
26 for us, Mr. Kingston, some of the problems which are  
27 facing medical students and interns which concern you?

28 MR. KINGSTON: Mr. Chairman, it would  
29 be fair to state that at the present time there is a  
30 good deal of concern among medical students as to the





1 future of the profession which they are aspiring to  
2 enter.

3 They do not feel that they are in a  
4 position as a group representing CAMSI/ACEMI to formulate  
5 a specific plan for comprehensive health care in Canada  
6 and, therefore, subscribe in principle to the philosophy  
7 as enunciated by organized medicine.

8 The matter of financial assistance is  
9 of great concern to the medical students because at  
10 least two-thirds to three-quarters of them express a  
11 desire for more financial assistance. The majority of  
12 these feel it is not the responsibility of the Federal  
13 Government to provide the money with no obligation to  
14 repay.

15 The matter of low principles of appli-  
16 cants to medical schools alarms the medical students  
17 particularly on the basis of the needs for the Canadian  
18 community in the manner of graduating medical men.  
19 They feel they have a responsibility and may be the  
20 best-qualified individuals in the community to approach  
21 high school students and undergraduate arts and science  
22 students with a view to studying medicine.

23 They also feel that if recruiting was  
24 to be successful and the number of applicants increased  
25 that so as not to deter future applicants and aspirants  
26 that the number of opportunities to study medicine in  
27 Canada should be increased and if possible made more  
28 flexible.







1 MR. HALL: Mr. Kingston I believe that  
2 you have a number of specific recommendations. Would  
3 you present those to the Commission please?

4 MR. KINGSTON: Our recommendations are as  
5 follows:

6 8. I The Canadian Association of Medical Students  
7 and Internes / L'Association Canadienne de Etudiants en  
8 Medecine et des Internes recommends that the Government  
9 of Canada, in league with the Provincial Governments  
10 and accrediting committees for teaching hospitals in  
11 this country, consider its responsibility as a fund-  
12 granting agency in doing all possible to assure the  
13 highest standards of learning and living conditions  
14 for internes and residents as well as for their  
15 remuneration.

16 9. II The Association /L'Association recommends  
17 that the Government of Canada encourage the institution  
18 of a system of basic standards for the learning and  
19 living conditions for internes and residents as well as  
20 their remuneration.

21 10. III The Association /L'Association recommends  
22 that the Government of Canada make available to a central  
23 fund or foundation appropriate grants of money to be  
24 used as interest-free loan capital in the support of  
25 the undergraduate medical student.

26 11. IV The Association /L'Association recommends  
27 that the Medical Research Council of Canada be  
28 encouraged and enabled to increase the grants  
29 available to Canadian universities for the summer  
30 employment of capable undergraduate students in research





1 fellowships.

2 12. V The Association /L'Association recommends  
3 that a survey of senior high school students be  
4 established, either under the auspices of, or with the  
5 assistance of the Government of Canada and the Dominion  
6 Bureau of Statistics, to study the interests and  
7 motivations of such students toward university careers,  
8 and any means of assisting them in acquiring  
9 information regarding such careers.

10 13. VI The Association /L'Association recommends  
11 that the Government of Canada in the consideration of  
12 the future needs for the health care of Canadians  
13 consider ways and means of encouraging recruitment  
14 of more applicants to the study of medicine.

15 14. VII The Association /L'Association recommends  
16 that the Government of Canada examine the disparity  
17 which exists in the availability of scholarship monies  
18 to students of natural sciences as opposed to the  
19 medical sciences, with a view to correcting this  
20 disparity, as a further stimulus to recruitment of  
21 applicants.

22 15. VIII The Association /L'Association recommends  
23 that the Government of Canada assist all interested  
24 organizations in establishing a nation wide council to  
25 assess accurately the future requirements for  
26 physicians in Canada, ways and means of assuring a  
27 sufficient number of opportunities for the study of  
28 medicine to meet this demand, as well as the increased  
29 number of applications accruing from any successful  
30 recruitment program.







1 If we might have your indulgence sir, we  
2 would like to have these presented en Francais.

3 M. le Président: Est-ce que vous avez  
4 quelque chose à ajouter à ce que monsieur Kingston a dit?

5 M. CLAUDE LAURIAULT: Monsieur le Président,  
6 je n'ai rien à ajouter mais seulement j'aimerais à  
7 énoncer nos recommandations en francais.

8 8. I L'Association des étudiants en médecine et  
9 des internes recommande que le gouvernement du Canada,  
10 conjointement avec les gouvernements provinciaux et  
11 les comités reconnus des hopitaux enseignants, dans ce  
12 pays, considèrent leurs responsabilités financières afin  
13 d'assurer les plus hauts standards au point de vue  
14 études, conditions de vie et rémunération pour les  
15 internes et résidents.

16 9. II L'Association recommande que le  
17 gouvernement du Canada aide à instituer un système de  
18 base au point de vue études, conditions de vie et  
19 rémunérations pour les internes et résidents.

20 10. III L'Association recommande que le  
21 gouvernement du Canada mette à la disposition d'une  
22 association ou d'un fond central, les octrois  
23 appropriés qui devront servir de capital pour des  
24 prêts sans intérêts aux étudiants sous gradués en méd-  
25 ecine.

26 11. IV L'Association recommande que le Conseil  
27 de recherche médicale du Canada soit favorisé et qu'il  
28 soit permis d'augmenter le nombre d'octrois aux  
29 universités Canadiennes, à titre de bourses de  
30 recherches, pour l'emploi d'été d'étudiants sous-gradués.







12. V L'Association recommande qu'il ait une  
enquête auprès des écoles secondaires soit sous les  
auspices de, ou avec l'assistance du gouvernement du  
Canada et du bureau National de statistiques afin  
d'étudier les intérêts et motifs de ces étudiants vis-  
a-vis une carrière universitaire, et les moyens de leur  
venir en aide avec les renseignements appropriés.

13. VI L'Association recommande que le  
gouvernement du Canada établisse des moyens pour  
favouser le recrutement d'un plus grand nombres  
d'étudiants en médecine.

14. VII. L'Association recommande que le  
gouvernement du Canada examine la dispanité qui existe à  
l'égard des bourses disponibles aux étudiants en  
sciences naturelles et les bourses disponibles aux  
étudiants en médecine, ceci, en vue de favouser le  
recrutment d'étudiants en médecine.

15. VIII L'Association recommande que le  
gouvernement du Canada aid toutes les organisations  
interes.sées à établir un conseil national pour évaluer  
précisément le besoin futur de médecines au Canada,  
et les manières et moyens d'assurer un plus grande  
nombre d'occasions, pour l'étude de la médecine, d'après  
ces besoins.

M. LE PRESIDENT: Merci bien, monsieur Lauriault.

MR. HALL: Mr. Chairman, Mr. Kingston and  
his colleagues will answer any questions, elaborate on  
any area that the Commissioners may wish.

THE CHAIRMAN: Mr. Kingston, regardless of  
the fact that you may not be able to speak for all





1 students, we may say that we are very pleased that  
2 you are here because it is desirable, I think, that  
3 this Commission should have the expression of views  
4 from students even though there may be valid reasons  
5 why these three dissenting schools are not here with  
6 you today.

7 Initially, have the medical students any  
8 views on any suggestion that has been made here and  
9 there that the term should be extended to say ten  
10 or eleven months with the idea of overall shortening  
11 the period in term of years? Simply the students  
12 views. We have heard from the teachers and from  
13 the professors.

14 MR. KINGSTON: I have only heard this  
15 suggestion discussed at Dalhousie University sir and  
16 I believe there is no solid front of thought regarding  
17 whether they would find this acceptable or desirable.  
18 I think most medical students would like to complete  
19 their training in a short period of time, if they  
20 felt it were possible. Most persons I have heard  
21 discussing it at Dalhousie University do not feel it  
22 is possible as far as the four years of professional  
23 training in medical school is concerned.

24 Some suggest that pre-medical training should  
25 be shortened or that basic science studied in the first  
26 year of medicine might be moved into the pre-medical  
27 years: biochemistry, particularly.

28 THE CHAIRMAN: Has your Association any  
29 views to express on the pedagogy of the schools of medicine  
30 that you represent? Should there be any drastic







1 changes in the method of instructions?

2 MR. KINGSTON: I would say they have not sir,  
3 in an organized fashion. Again, you hear many  
4 individual comments, some complaints, but I do not  
5 believe I have ever heard this discussed in an  
6 organized manner nor any concrete suggestions for  
7 alterations in the present methods.

8 THE CHAIRMAN: Now we hear much about  
9 there has been an apparent falling off of prospective  
10 medical students. Is it your view or have you any  
11 views that the preliminary entrance requirements have  
12 anything to do with that?

13 MR. KINGSTON: I think most medical students  
14 when they endeavour to state in retrospect what their  
15 views on medicine was prior to taking it, that the  
16 length of the course was one deterrent that they  
17 consider and in this regard the pre-medical training  
18 would represent an additional hurdle to most of them.

19 They are unable at that stage to appreciate  
20 what is attempting to be done on asking them to  
21 complete a course in arts or science and once they are  
22 in medicine, most of them express little regret.

23 THE CHAIRMAN: In addition to the time, what  
24 about the standard, the entrance standard. That is  
25 the 60 or 65 per cent rating in the academic work?

26 MR. KINGSTON: I do not think any medical  
27 students complain of the academic requirements for  
28 entrance. I do believe that a good many high school  
29 students and undergraduate medical students possibly  
30 feel that it is much higher than it actually is.





1 THE CHAIRMAN: What do you mean by that?

2 MR. KINGSTON: I believe that there are people,  
3 many people, possibly, although this is only a  
4 personal opinion, who feel that they cannot attain  
5 acceptance in a medical school with an average of  
6 65 per cent. They feel it's possibly closer to 75  
7 or 80 per cent.

8 THE CHAIRMAN: Is that a hang-over from the  
9 post war period?

10 MR. KINGSTON: I would think this represents  
11 a hang-over from that period.

12 THE CHAIRMAN: What about graduation  
13 requirements, have you any view on whether the  
14 standards are set too high there?

15 MR. KINGSTON: The graduates from medicine?  
16 I have never heard anyone honestly state that he  
17 felt that the graduation requirements were too high.

18 THE CHAIRMAN: Have you any views on what  
19 is the principal reason for the loss of students  
20 throughout the course, in the course of the four year  
21 program at the university?

22 MR. KINGSTON: I do not have any documented  
23 means of evaluating this but certainly there are  
24 three major areas in which we see students dropping  
25 out. One is the student who was not completely  
26 motivated or keenly motivated before applying. Another  
27 is a student who becomes medically or physically  
28 incapable of continuing and the student who  
29 academically is unable to comply with the requirement.

30 THE CHAIRMAN: Have you any appreciable





1 group, is there any appreciable group that falls  
2 out because of lack of money?

3 MR. KINGSTON: I would think not sir.  
4 Certainly not at Dalhousie University.

5 THE CHAIRMAN: Amongst others?

6 MR. KINGSTON: I am unacquainted with anyone  
7 -- I have heard of cases that students have been  
8 required to leave for the summer vacation and then  
9 remain out for an additional year in order to  
10 continue financing but I do not think anyone abandons  
11 the course completely for reasons of financial  
12 embarrassment.

13 THE CHAIRMAN: Mr. Lauriault, have you got  
14 any views to express on these questions in addition  
15 to what has been said?

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1 MR. LAURIAULT: As far as dropping out,  
2 I believe - this is personal again - here in Ottawa I  
3 don't believe anyone drops out for financial reasons. .

4 As far as lengthening the school year  
5 in order to shorten the course, here at Ottawa most  
6 students would be in favour of this, but again I think  
7 the main deterrent is the financial need of many of  
8 these students.

9 THE CHAIRMAN: The opportunity to earn  
10 money in a three or four-month period.

11 MR. LAURIAULT: Yes.

12 COMMISSIONER BALTZAN: Mr. Chairman,  
13 ladies and gentlemen, I congratulate CAMSI/ACEMI. I  
14 see you are in the 25th year.

15 Would you turn with me to page 3,  
16 paragraph 20:

17 "In the majority of Canadian Medical  
18 Colleges, at the present time, the  
19 subject of 'Medical Economics',  
20 including a study of prepaid Medical  
21 Health Care, is an integral part of  
22 the curriculum in Public Health and  
23 Preventive Medicine".

24 First, I would say it is too bad some  
25 of us were born so long ago. However, my question is:  
26 do you find that the emphasis and the theories and the  
27 presentation of the subject of medical economics and  
28 medical care varies with features?

29 You are Canada-wide, are you not?

30 MR. LAURIAULT: Yes.





1 COMMISSIONER BALTZAN: Does it vary  
2 with schools and vary with provinces?

3 MR. KINGSTON: There is no question in  
4 my mind, having spoken with students in most medical  
5 schools in Canada regarding the subject, that the  
6 content, proportion of the course devoted to medical  
7 economics varies in degree and intensity and the volume  
8 that would be covered.

9 What it is due to I am not prepared  
10 to say. Whether or not it is connected with the indivi-  
11 dual responsible for presenting the course, I am not  
12 prepared to say.

13 COMMISSIONER BALTZAN: Is the subject  
14 presented to you in a broad sense, that is considering  
15 points of view so that you might reach your own deduc-  
16 tions, let's put it that way?

17 MR. KINGSTON: I have heard opinions  
18 that it has been presented in a rather biased manner in  
19 some schools. However, perhaps I could ask one of the  
20 members attending with me how they feel about it.

21 MR. ROSENWALD: I found that one-third  
22 of the time spent on preventive medicine was devoted to  
23 the study of various health plans, and we discussed  
24 them in seminar groups and it was less of a didactic  
25 teaching than investigation amongst ourselves of the  
26 various plans and we ourselves reached our own conclu-  
27 sions.

28 COMMISSIONER BALTZAN: In other words,  
29 it is fairly well presented so that you might make your  
30 own deductions, reach your own conclusions?







1 MR. ROSENTHAL: That is correct.

2 COMMISSIONER BALTZAN: Well, that is  
3 fair. In the same paragraph, last two lines:

4 "Further, it is a common observation  
5 that some plans are frequently mis-  
6 quoted, or wrongly described, when  
7 used as models by persons addressing  
8 the public".

9 The question is: would you include  
10 also people outside the profession or people inside the  
11 profession?

12 MR. KINGSTON: I think in all fairness  
13 it would include both, sir.

14 COMMISSIONER BALTZAN: Page 7, para-  
15 graph 29, referring to married people in the study of  
16 medicine, you quote here internships, 40 to 60%, and  
17 I suppose you include residents, or is the percentage  
18 greater in those people?

19 MR. KINGSTON: In the next sentence  
20 of that paragraph I would respectfully direct your  
21 attention to the statement that "Although a figure is  
22 unavailable at the present time, it is fair to state  
23 that the proportion of married persons entering resi-  
24 dency training is far greater".

25 COMMISSIONER BALTZAN: You are quite  
26 correct. Have you information about the proportion of  
27 married undergraduate students, that is before their  
28 internship?

29 MR. KINGSTON: We have sample studies  
30 that have been performed locally by CAMSI/ACEMI





1 organization within their own colleges. However, we  
2 deemed it more factual possibly to lump these in a  
3 national average covering a range of 40% rather than  
4 present any one on a study which might be an unrealistic  
5 bias, where, say, in the City of Winnipeg the students  
6 have conducted one of their own in a four-year study  
7 of medicine there.

8 COMMISSIONER BALTZAN: Can you say the  
9 number of students who were married, in their first  
10 year?

11 MR. KINGSTON: It is a very variable  
12 situation, but my guess would probably be influenced  
13 by my own experience personally. I happened in a class  
14 where a large percentage of the students were married  
15 on entrance.

16 COMMISSIONER BALTZAN: You belonged to  
17 that group?

18 MR. KINGSTON: Yes, and the class  
19 following had far fewer married. So I think our class  
20 would be 20%, 23%, and the class behind possibly only  
21 10%.

22 COMMISSIONER BALTZAN: Thank you. On  
23 the same page 7, paragraph 32, you make a plea on the  
24 basis of full-time staff physician's annual salary, and  
25 you put a certain proportion for interns and residents.  
26 What is the average for, say, first-year internship,  
27 first-year residency in Canada?

28 MR. KINGSTON: The average would  
29 definitely fall in the range of \$100, \$125 a month,  
30 usually in excess of board and laundry. Where it does





1 vary, in some provinces residents of ---

2 THE CHAIRMAN: We are talking about  
3 the first year intern now.

4 COMMISSIONER BALTZAN: That is the  
5 first year.

6 MR. KINGSTON: Yes.

7 COMMISSIONER BALTZAN: And even intern-  
8 ships vary from province to province, but that would be  
9 the national average.

10 MR. KINGSTON: That would be an average,  
11 although it does go as high as \$300 a month, and this  
12 average falls within the range of variation and it is  
13 not in excess of the high but it is in excess of the  
14 low offered today.

15 COMMISSIONER BALTZAN: Do you consider  
16 it adequate as it stands today?

17 MR. KINGSTON: No, sir.

18 COMMISSIONER BALTZAN: It should be  
19 higher?

20 MR. KINGSTON: Yes.

21 COMMISSIONER BALTZAN: To accommodate  
22 most people, specially the married.

23 MR. KINGSTON: Not only the married.  
24 I think the intern should be regarded as someone  
25 learning while in service. People in service are earning  
26 a living wage, and we feel that the present remuneration  
27 does not represent a living wage.

28 COMMISSIONER BALTZAN: Would you turn  
29 to page 10, your schematic drawing in the matter of  
30 borrowing. You say that the first year - is that the  
first year of medicine?







1 MR. KINGSTON: Yes, sir.

2 COMMISSIONER BALTZAN: And on the same  
3 sketch all the way to the fourth year.

4 MR. KINGSTON: Yes.

5 COMMISSIONER BALTZAN: Repayment would  
6 begin when the individual had left hospital?

7 MR. KINGSTON: Completed his internship  
8 portion of his training, yes, unless he had post-graduate  
9 training.

10 COMMISSIONER BALTZAN: I notice you  
11 predict a sum of something like nine million dollars.  
12 Would that be your estimated capital fund required to  
13 start this ball rolling?

14 MR. KINGSTON: We estimate an initial  
15 fund requirement of five million dollars at the present  
16 time but project anticipated applications of ten to  
17 fifteen years of approximately nine million dollars,  
18 based on the projections as elaborated on the study by  
19 the Canadian Medical Association.

20 COMMISSIONER BALTZAN: I have learned  
21 a good deal from your medical economics. Thank you  
22 very much.

23 MR. KINGSTON: Thank you, sir.

24 COMMISSIONER VAN WART: Continuing  
25 with your Table 10, you estimate \$1,600 per year, total  
2 26 four years \$6,400. What is the average cost per medical  
27 student per year at the University?

28 MR. KINGSTON: Estimates, which are  
29 rather unofficial - I believe they have been officially  
30 studied in the Halifax area - are \$1,600 a year.





1 Unofficial estimates from Montreal are \$1,600 to \$2,200  
2 annually. This is complete cost to the student to live  
3 on and to pay his tuition books for one year. I haven't  
4 had a figure quoted from Toronto.

5 COMMISSIONER VAN WART: Do you antici-  
6 pate any difficulties in the repayment of this \$6,400  
7 when the student leaves his internship?

8 MR. KINGSTON: Over a period of six  
9 years?

10 COMMISSIONER VAN WART: Yes.

11 MR. KINGSTON: Under the present  
12 system of income of a general practitioner in the  
13 national average, we would not anticipate difficulty.  
14 If his situation altered in any way, then it would have  
15 to be considered.

16 COMMISSIONER VAN WART: Are you taking  
17 into consideration the expense in setting up practice  
18 in the first five years?

19 MR. KINGSTON: The payment of the loan  
20 honoured under this system might require establishment  
21 of a further credit in order to establish practice in  
22 the office. We were cognizant of that when we recommended  
23 this system of repayment.

24 COMMISSIONER VAN WART: You don't  
25 anticipate a hardship?

26 MR. KINGSTON: No, not a hardship.  
27 Inconvenience, possibly. This was discussed by the  
28 committee working on this scheme, and they felt that  
29 in the early years where a person starting a practice  
30 was a very slow process there might be difficulty or







1 inconvenience, but not hardship.

2 COMMISSIONER VAN WART: On what annual  
3 income would you base your calculations?

4 MR. KINGSTON: We based it on an  
5 average income of general practitioners of \$16,000,  
6 which I believe was made three years ago. However, we  
7 recognize the fact ---

8 COMMISSIONER VAN WART: That is gross?

9 MR. KINGSTON: Yes, gross, sir. The  
10 initial period we realize would not return this amount  
11 of money.

12 COMMISSIONER VAN WART: I think you  
13 ought to recalculate your basis again, because I think  
14 you will have great difficulty in repaying your \$6,400  
15 starting in practice in the first five or six years.  
16 I think you ought to take a realistic look at that.

17 COMMISSIONER GIRARD: Mr. Kingston,  
18 to your knowledge have any medical students in the  
19 Province of Quebec voiced an opinion on the use of  
20 training grants? Those are the grants they get and for  
21 which they have to repay 40%.

22 MR. KINGSTON: No, I am unaware of  
23 these grants, and I have not heard statements regarding  
24 them.





1 COMMISSIONER GIRARD: Do you know of any  
2 other province where these grants are made? They  
3 are not made only to medical students, they are  
4 youth training grants.

5 MR. KINGSTON: By whom are they sponsored?

6 COMMISSIONER GIRARD: By the government,  
7 and the student repays forty per cent of the grant,  
8 therefore, 60 per cent of the grant is free to the  
9 student.

10 MR. KINGSTON: The only comparable situation  
11 in other provinces of which I am aware are dominion-  
12 provincial loans, and they were made at the University  
13 of Saskatchewan. I believe they were made through  
14 the Provincial Building auspices in Nova Scotia, and  
15 a similar system prevails, where the student borrows  
16 \$100.00 and is granted \$200.00 in addition. At least,  
17 that was the system employed when I was taking my pre-  
18 medical training.

19 COMMISSIONER GIRARD: That is purely  
20 provincial?

21 MR. KINGSTON: Dominion-provincial monies,  
22 but disbursed by the provincial government to the  
23 university.

24 COMMISSIONER GIRARD: So you don't know how  
25 the students in the Province of Quebec feel about the  
26 youth training grants. I understood they thought they  
27 were all right, but not large enough. They had to  
28 be paid 40 per cent.

29 MR. KINGSTON: I know that there has been  
30 some delay this particular year in the Province of





1 Quebec in the students receiving their grants, which  
2 has created considerable inconvenience, but I was  
3 unaware that these were called youth training grants,  
4 and I don't know whether they are the same grants  
5 we are talking of.

6 COMMISSIONER GIRARD: I believe they are,  
7 because they didn't come in until January.

8 THE CHAIRMAN: Mr. Kingston, you have a body  
9 of students, some of whom undoubtedly are looking  
10 forward to specialized practice, others to general  
11 practice?

12 MR. KINGSTON: Yes.

13 THE CHAIRMAN: As representing the students,  
14 are your organizations satisfied with the content of  
15 the courses, in so far as fitting the students for  
16 general practice is concerned, rather than just  
17 fitting him to a point where he is going to go on  
18 to specialize?

19 MR. KINGSTON: Again, I think I could only  
20 express an opinion for Dalhousie students in this  
21 regard, if this is useful to you at all.

22 THE CHAIRMAN: Yes.

23 MR. KINGSTON: They frequently express concern  
24 that the course is not geared to training general  
25 practitioners, and in expressing such concern our  
26 faculty say that the course is not intended to train  
27 general practitioners, but to be able to enter  
28 general practice as well as any field of specialty.

29 COMMISSIONER FIRESTONE: In paragraph 10,  
30 page 2, you recommend that a central fund or foundation







1 be established as an appropriate fund to provide  
2 interest-free loans to undergraduate medical students.  
3 Would you support a somewhat different arrangement,  
4 or would you feel that your students would support a  
5 somewhat different arrangement, whereby the Canadian  
6 government might guarantee to the chartered banks  
7 students loans made both to undergraduate students  
8 and to graduate students, with a repayment arrangement  
9 somewhere along the lines which you have proposed, but  
10 the difference being that the student will be going  
11 to his bank and filling out a form with the  
12 particulars required, and then an examination of  
13 his record and other requirements, and then on  
14 approval and a guarantee by the government, such a  
15 loan would be made? It is true these loans will  
16 carry interest, but one could follow two ways. One  
17 could defer the payment of the interest until the  
18 student becomes a fully qualified professional, or  
19 secondly, the government could subsidize such a  
20 scheme. How would your student body feel about such  
21 a proposal, whereby the chartered banks would perform  
22 this lending function?

23 MR. KINGSTON: Some students have discussed  
24 the system which has been instituted in the United  
25 States in this regard with me. They feel that it has  
26 advantages over a plan such as we recommend here. I  
27 believe in speaking with students however, that  
28 there would be a sizeable number who would prefer to  
29 make use of money which is presently available through  
30 such sources as the tri-services plan, where they do





1 not realize, or do not see any interest being charged  
2 on the money that is given them. They simply agree  
3 to return in service the money, or the debt which they  
4 have incurred. There would be undoubtedly a group  
5 which would feel that the interest, provided it were  
6 not excessive, was just, and would prefer to pay the  
7 interest, rather than commit themselves to service  
8 at the time of their financial need.

9 COMMISSIONER FIRESTONE: In other words,  
10 presuming that the current bank rates are considered  
11 a reasonable rate, that you would feel some of the  
12 students would prefer such a scheme, in order to not  
13 find it necessary to accept what in effect are tied  
14 loans, tied in the sense that if you complete training  
15 under this loan arrangement you have to serve in a  
16 particular area, and so on, so that there may be  
17 some students that you feel would prefer an arrangement  
18 whereby they are not tied to serve in any particular  
19 area?

20 MR. KINGSTON: Very definitely sir.

21 COMMISSIONER FIRESTONE: Now, why did you  
22 in your recommendation to limit this proposal to the  
23 support of the undergraduate medical student? Would  
24 you not feel that perhaps the graduate student may  
25 also require access to such loan arrangements?

26 MR. KINGSTON: Perhaps, although this  
27 consideration, limiting ourselves as we have, probably  
28 arises more from constituency considerations than  
29 that we think some of the graduates do not need money.

30 COMMISSIONER FIRESTONE: Presumably some of







1 you will become graduates?

2 MR. KINGSTON: Yes.

3 COMMISSIONER FIRESTONE: So you wouldn't think  
4 that your student body would support a scheme looking  
5 at the undergraduate rather than the graduate?

6 MR. KINGSTON: Yes.

7 COMMISSIONER McCUTCHEON: He is paid once  
8 he starts his internship?

9 MR. KINGSTON: Yes, I think the majority of  
10 medical students and this is only a personal opinion,  
11 but I think as a medical student I regard the  
12 difficulties to be encountered financially in graduate  
13 studies to be far less than they are in the under-  
14 graduate level.

15 COMMISSIONER FIRESTONE: Well, are there not  
16 graduate students who do not get the \$125.00  
17 internship?

18 MR. KINGSTON: I would say that since last  
19 year that there are very few, if any, students who  
20 enter their junior internships for less than \$100.00  
21 a month. However, in some schools, and including  
22 Dalhousie, you still pay tuition fees, so that by the  
23 time you have completed paying your tuition fees and  
24 incidentals, if you are receiving from \$100.00 to  
25 \$125.00 a month, less than half of this is available  
26 as earnings.

27 COMMISSIONER BALTZAN: If you pay tuition  
28 fees, do you earn your internship?

29 MR. KINGSTON: That is correct sir.

30 COMMISSIONER FIRESTONE: In paragraph 14 you





1 refer to the difference in scholarship monies available  
2 to students of the natural sciences as against students  
3 in the medical sciences. Do you as a student body  
4 recommend a particular amount which you would feel  
5 would be a reasonable amount across the board as a  
6 scholarship that could be made available to under-  
7 graduate students in the medical field?

8 MR. KINGSTON: At the present time the feeling  
9 among the medical students in Canada whom I have  
10 contacted personally and discussed this point with,  
11 feel very definitely that scholarship money should  
12 not be requested from the federal government at the  
13 present time. They feel, however, that anyone  
14 concerned with recruiting aspirants to medical study  
15 should be cognizant of the fact that some individuals  
16 would be influenced to enter the study of a basic  
17 science rather than medicine on the basis of the money  
18 that was available.

19 COMMISSIONER FIRESTONE: After all, sir,  
20 if this Commission after all its investigations are  
21 completed find that to provide expanded medical service  
22 to Canadians we require many more medical doctors in  
23 Canada, and we are interested in getting more young  
24 people to enter the medical profession, how do you  
25 feel we should go about it? Do you feel that  
26 scholarships should not be made available to induce  
27 promising young men to enter the field? How are we  
28 going to do it?

29 MR. KINGSTON: Again a personal opinion. As  
30 the result of discussions with students, I think the





1 majority of students would welcome a scholarship  
2 support, provided they felt that there was not an  
3 obligation engendered by accepting such monies, and  
4 further that they would not like to think that this  
5 in any way would alter their opportunities to practice  
6 medicine as they imagine it when they enter the study  
7 of medicine.

8 COMMISSIONER FIRESTONE: In other words,  
9 you are expressing the opinion that you feel that  
10 your student body are in favour of scholarships as a  
11 means of attracting young men, but you are objecting  
12 to the principle of tied scholarships, to practice in  
13 a particular area?

14 THE CHAIRMAN: Mr. Kingston, are you actually  
15 going a little further and in a nebulous way saying  
16 if we accept money from government today, government  
17 will make demands on us tomorrow?

18 MR. KINGSTON: I think the medical student  
19 gets down to thinking at the level of the taxpayer,  
20 saying how can we ask the taxpayer to give us money  
21 with no ties, and at the same time suggest that we  
22 don't want the taxpayer to have any more to do with  
23 the way we earn our money after we leave school.

24 COMMISSIONER FIRESTONE: Are you not saying  
25 in paragraph 14 that there is a disparity between  
26 the scholarship monies available to students in the  
27 natural sciences as compared with the medical sciences?  
28 Are you not saying that there is in fact a discrimination  
29 between students in the natural sciences and students  
30 in the medical sciences?







1 MR. KINGSTON: I certainly do not feel that  
2 the medical students in Canada would like me to lead  
3 them in complaining about this. However, I do believe  
4 that the people interested in recruiting students should  
5 consider this as one point of attrition of those who  
6 enter medical and end up in basic sciences.

7 COMMISSIONER FIRESTONE: If we want to  
8 train more medical people here, we must have more young  
9 people in the medical field, and the question we are  
10 posing to you is, how are we going to do it?

11 MR. KINGSTON: We have suggested in our brief  
12 that a study be made of the motivation of high school  
13 students. Why do some set a course toward medicine,  
14 regardless of its length and expense? Why do others  
15 become detracted along the way? We feel that  
16 finances and financial assistance in the form of  
17 scholarship or loan monies only represent one facet  
18 of the motivation, and therefore that no one is at  
19 the present time qualified to say even what would  
20 happen in recruiting by adding scholarship monies to  
21 the field.

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1 COMMISSIONER FIRESTONE: This is a  
2 very good suggestion and this Commission, I might say,  
3 is undertaking such studies. We are trying to find  
4 out more about the motivation of young people. Let us  
5 assume this is so that a number of our people say they  
6 cannot afford medicine, cannot afford it, what are  
7 you going to do about it, just restrict medicine to the  
8 people that can afford it?

9 MR. KINGSTON: A very controversial  
10 opinion evolves around whether or not if a person is  
11 sufficiently well-motivated to study medicine he is  
12 not prepared to finance his own medical education if  
13 you assist him by letting him have the credit, the  
14 money, at the time that he needs it most but to be  
15 repaid.

16 To some people very definitely scholar-  
17 ships would suggest an attraction. Then, there is a  
18 controversy as to whether or not the motivation is due  
19 to a sincere desire to study medicine and practise it  
20 or a desire to study under a subsidized scheme.

21 COMMISSIONER FIRESTONE: Has this point  
22 been discussed amongst your student body as to whether  
23 you should have medical scholarships or not?

24 MR. KINGSTON: Very definitely and in  
25 accepting the brief one university wired congratulations  
26 that we were not requesting "a handout" at the present  
27 time.

28 COMMISSIONER FIRESTONE: That is one  
29 university but how about some others?

30 MR. KINGSTON: This would represent







1 the feeling, I think, of the majority of students at  
2 the universities visited.

3 COMMISSIONER FIRESTONE: How many uni-  
4 versities did you visit?

5 MR. KINGSTON: Nine of twelve.

6 COMMISSIONER FIRESTONE: And you feel  
7 that there is no need for a medical scholarship scheme?

8 MR. KINGSTON: In terms of need, no;  
9 desirability, possibly with some persons but not the  
10 majority of students as far as government scholarships  
11 are concerned.

12 COMMISSIONER FIRESTONE: And the  
13 reason you are saying there is no need is because as  
14 far as you know most of the students that want to enter  
15 medicine can afford to pay for tuition as well as ---

16 THE CHAIRMAN: He has not said that,  
17 if you are paraphrasing what he said. You said he said  
18 that and I think it is desirable when we put words in  
19 a person's mouth that we should put what he said  
20 correctly.

21 COMMISSIONER FIRESTONE: We might have  
22 Mr. Kingston use his own words, I would prefer that.

23 THE CHAIRMAN: I think we have carried  
24 this far enough. I do not think there is any purpose  
25 in this Commission trying to make Mr. Kingston think  
26 his views are wrong. He is here to express his views  
27 whether they are right or wrong and it is up to us to  
28 judge if they are not in the terms of the way they are  
29 put forward whether they are right or wrong.

30 We cannot convince Mr. Kingston and





1 the students of what is good for them.

2 MR. KINGSTON: Perhaps Dr. Firestone  
3 would like to hear other members of the executive  
4 express opinions be they personal or those gathered  
5 from discussions with other students.

6 COMMISSIONER FIRESTONE: I am very  
7 happy with your own views, as long as you can express  
8 them I would like you to answer. One final question;  
9 would you say there are students that would aspire to  
10 take up medicine that do not do so because they have  
11 not got the means and the availability of scholarships  
12 might make the difference between them being able to  
13 enter medicine or not? Express your own views if you  
14 wish.

15 MR. KINGSTON: I would say the feeling  
16 across the country is that those people who are deterred  
17 from studying medicine through reasons of financial  
18 need are uninformed of the availability of funds to  
19 assist them in financing their own education.

20 COMMISSIONER FIRESTONE: Mr. Kingston,  
21 if we turn to paragraph 32 on pages 7 and 8 you recommend,  
22 the top of page 8, that minimum standards of remuneration  
23 for first-year interns should be established in Canada  
24 at a rate no less than \$2,600 per annum with an annual  
25 review of this minimum.

26 Now, this is a desirable sort of objec-  
27 tive. You appreciate this is a submission to the Royal  
28 Commission which is advising the Federal Government and  
29 we would like to have your ideas of how these recommenda-  
30 tions can be implemented.







1 MR.KINGSTON: Well, in our specific  
2 recommendations on this subject, this part you are  
3 quoting now is contained within the body of the brief;  
4 in our specific recommendations we use the word and  
5 the term "encourage". We feel it is primarily the  
6 responsibility of accrediting bodies to establish  
7 minimum standards not only for remuneration but instruc-  
8 tion and living standards for interns in residence.

9 However, we do feel that if the Govern-  
10 ment considers any change in the present system which  
11 might increase its responsibility that this is a major  
12 consideration, that the time has possibly come when  
13 recognition of the fact that people should not receive,  
14 as has often been quoted, pin money or cigarette money  
15 while they are learning.

16 These people do a valuable job even  
17 though they do learn while they are doing it. We do  
18 not feel the Government has a major responsibility at  
19 the present time except where it may be granting money  
20 to hospitals employing interns.

21 THE CHAIRMAN: Because these hospitals  
22 do employ interns as part of the operating costs of the  
23 hospital.

24 MR. KINGSTON: And there it is a matter  
25 of whether or not the hospital will be accredited as to  
26 whether it will be supported financially by the Govern-  
27 ment. That would represent encouragement.

28 COMMISSIONER FIRESTONE: Thank you,  
29 Mr. Kingston.

30 THE CHAIRMAN: Thank you very much,







1 Mr. Kingston and gentlemen.

2 We will have a short recess now.

3  
4 --- Short Recess

5  
6 THE CHAIRMAN: If you will come to  
7 order we will continue with the submission of the  
8 Canadian Dental Association.

9 SUBMISSION OF THE CANADIAN DENTAL ASSOCIATION

10 (Continued)

11 THE CHAIRMAN: Dr. Gullett, there was  
12 perhaps one further question in connection with fluori-  
13 dation. You were talking of the conditions in England,  
14 what is the situation there? Is there fluoridation of  
15 the communal water supply to any extent?

16 DR. GULLETT: The government has either  
17 two or three experimental projects going on at centres  
18 in England at the present time.

19 THE CHAIRMAN: It is still in the  
20 experimentation stage.

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1 DR. GULLETT: The British Government set  
2 up a Commission who came to Canada and the United  
3 States, must be as much as five years ago, and the  
4 report made by the Commission is fully favourable,  
5 without any qualification to fluoridation so following  
6 that report the Government set up experiments and  
7 the results are coming out from those experiments  
8 which are similar to the experiments that we have  
9 heard about years ago on this Continent.

10 THE CHAIRMAN: Now here in the brief you  
11 emphasize there was a shortage of dental manpower.  
12 Is it conceivable that a class of person, such as  
13 the denturist claims to be, could be trained who  
14 would do considerable volume of the work now being  
15 done by dentists in connection with dentures and  
16 that kind of thing?

17 DR. GULLETT: The policy of the Association  
18 is --

19 THE CHAIRMAN: I do not want to put it on  
20 a question of policy. I think we understand the  
21 policy. You don't want to have anything to do with  
22 it.

23 Is it possible to foresee that a body could  
24 be trained which working independently could repair  
25 dentures, that kind of thing, that would take a  
26 considerable load off the back of the practising  
27 dentist and leave him freer to do other dental work?

28 DR. GULLETT: In a sense you are stating what  
29 we believe in the creation of auxiliaries.

30 THE CHAIRMAN: But you are saying those







1 auxiliaries must work under the immediate direction of  
2 a dentist?

3 DR. GULLETT: Yes, because of the danger to the  
4 public health without the supervision and direction  
5 of the best qualified personnel within a profession  
6 who takes the responsibility for the patient's welfare.

7 THE CHAIRMAN: In other words, you cannot  
8 see this body working independently?

9 DR. GULLETT: No.

10 THE CHAIRMAN: What is your view on the  
11 practice in New Zealand where the dental nurse does  
12 filling and extractions amongst the younger children?

13 DR. GULLETT: We believe the New Zealand  
14 dental nurse is a good technician but we certainly do  
15 not believe that she is a diagnostician.

16 In other words, if you are going to attempt  
17 to improve the dental health, then you have to have the  
18 ~~diagnost~~ic command and again the responsibility of the  
19 patient in the hands of the qualified individual.

20 Now we are very familiar with the New Zealand dental  
21 nurse program. Admittedly they do a great quantity  
22 of work but we are interested in what the condition is  
23 of the adult health and dental health of the patient  
24 as a result of that.

25 THE CHAIRMAN: I am restricting my questions  
26 to the children in the schools as it is practised in  
27 New Zealand?

28 DR. GULLETT: That is right.

29 THE CHAIRMAN: Does the dental profession in New  
30 Zealand take an adverse position as to what is being





1 done there by the dental nurse in the school?

2 DR. GULLETT: It depends on which section  
3 you are talking to.

4 THE CHAIRMAN: You mean there is a divided  
5 opinion?

6 DR. GULLETT: Yes. At the bottom, in a  
7 footnote at the bottom of 42 I think is a very  
8 explanatory note. This program has been in force  
9 now for thirty-five years in New Zealand or longer and  
10 we just do not like what we see among adults as a result  
11 of the program.

12 It gets back to the standpoint of prevention  
13 and control and if you are going to have prevention  
14 and control in your program, then you are going to  
15 have to have the best diagnostician you have in order  
16 to take the responsibility.

17 THE CHAIRMAN: Now in your diagrams 19 (1)  
18 and (2) and (3) you give figures there about the  
19 number of women dentists in various countries. We  
20 see at Chart 19 (8) -- it's really table 19 (1) I think,  
21 that the percentage of women dentists in the United  
22 States is one per cent. In Canada two per cent. West  
23 Germany 13. Denmark four. Probably take a sort of  
24 representative country. What is the explanation of  
25 such a tremendous variation in the figures?

26 DR. GULLETT: This gets back to the customs  
27 which exist in the countries concerned. We have what  
28 we think are the best openings possible for women in  
29 dentistry. Personally I talk to many of these  
30 girls and their parents, and it is not the girl where







1 the trouble comes. It's the parents. The parents  
2 see no reason why they should lay out money for a  
3 dental course when they can send the girl, a lot  
4 cheaper, to an arts course because she is going to  
5 get married in the final year anyway and that is where  
6 the objection comes and the greatest obstacle we have.

7 We have wonderful openings for women and we  
8 would very much like to see our percentage up. This  
9 situation is even worse in the United States for the  
10 same reason.

11 THE CHAIRMAN: It's one per cent there?

12 DR. GULLETT: Yes.

13 THE CHAIRMAN: Great Britain eight per cent?

14 DR. GULLETT: Yes. Now the two per cent  
15 we have in this country, I don't know the exact  
16 percentage but quite a large number of them are foreign  
17 graduates in Europe who have come to this country and  
18 have been able to qualify and that is why we are two  
19 per cent and they are one per cent in the United  
20 States very probably to a large measure.

21 THE CHAIRMAN: I see the figure showed two  
22 persons in Saskatchewan?

23 DR. GULLETT: That is right.

24 THE CHAIRMAN: Now do you think there is  
25 anything that could be done to tap that resource?

26 DR. GULLETT: As the parent is the objector,  
27 one or two of our recommendations might help  
28 a little in respect to fees and some other things. If  
29 the course in dentistry and in general in the health  
30 science, if the fee structure and all things were equal-







1 ized with other courses of the University, it would be  
2 a factor undoubtedly.

3 THE CHAIRMAN: Thank you very much. Mr.  
4 Firestone?

5 COMMISSIONER FIRESTONE: Dr. Gullett if I may  
6 refer to paragraph 133 on page 42 and I quote:

7 "The Canadian Dental Association  
8 cannot recommend a national dental  
9 insurance plan at this time."

10 What are the reasons why you feel that a  
11 national dental insurance plan cannot be introduced at  
12 this time? Does that mean that it could be introduced  
13 over a period of time given the gradual development of  
14 let's call it dental resource, in a very broad way?

15 DR. GULLETT: Regardless of all other reasons,  
16 it just would not be honest to recommend it at this  
17 time. As to what our future statements might be, I just  
18 do not care to make it at the moment but we are in no  
19 position -- if you haven't the personnel; if you  
20 haven't the facilities why should you say that you  
21 can support a plan?

22 COMMISSIONER FIRESTONE: Just trying to  
23 understand what the phrase "at this time" means. I  
24 take it it means that you feel there is inadequate  
25 personnel available to do the job?

26 DR. GULLETT: That is right.

27 THE CHAIRMAN: But you have no objection to  
28 a plan to come into effect when there is adequate  
29 personnel?

30 DR. GULLETT: I did not make that statement.





1 COMMISSIONER FIRESTONE: I say you did not  
2 make it but I am just asking you as a question.

3 DR. GULLETT: I think we would have to give it  
4 careful consideration at a time when we had the  
5 personnel and the facilities.

6 COMMISSIONER FIRESTONE: You understand Dr.  
7 Gullett when a Nation plans a program it has to think  
8 ahead. You cannot wait and tell people please take  
9 up dentistry and we will find a job for you. You  
10 plan a program in providing dental services and the  
11 people that will render those services. Therefore, if  
12 a nation plans a program you have got to plan both the  
13 demand side and the supply side and I am coming to you  
14 and asking a question: assuming we take the advice  
15 that the Canadian Dental Association is giving us, you  
16 have not got enough resources to introduce a much  
17 broader coverage and a much broader program, even if the  
18 population you have for such a program, was available  
19 a Nation that wants to plan such a program has to do  
20 something to encourage you people to enter the dental  
21 prfession, first make other arrangements which are  
22 covered in auxiliary personnel, clinics, staff, one  
23 hundred and one things and at the same time devise a  
24 plan that over a period of time would give the Canadian  
25 people a more comprehensive dental care than the  
26 Canadian people may want and therefore my question  
27 comes back again to your basic principle. We can  
28 understand the reasons that you made -- you have given  
29 them in great detail as to why you feel a national  
30 dental insurance plan is not recommended at this time.







1 Do I understand that if arrangements could  
2 be worked out to correct the facilities in terms of  
3 manpower and terms of auxiliary personnel; in terms  
4 of equipment, clinics and other facilities, that you  
5 would feel that one could work towards such a plan?

6 DR. GULLETT: The only guide we have as to  
7 the progress is our experience in the past. It took  
8 us fifteen years ardently to be able to get any  
9 movement to build a new dental school in this country.

10 We hope that it won't take so long to get  
11 the next one. We have no guide as to what will occur  
12 in that respect.

13 Now no matter what the conditions might be,  
14 we would still feel what we have laid down here in  
15 this statement is the correct approach to the dental  
16 health problem. It would not make much difference  
17 how much personnel we had or how much facilities. The  
18 only difference would be we would move forward more  
19 quickly.

20 COMMISSIONER FIRESTONE: Well if we had  
21 more personnel Dr. Gullett could one not provide more  
22 services and could one not develop a plan to make the  
23 services available to all Canadians?

24 DR. GULLETT: Even in countries that have  
25 compulsory plans at the present time, of which Norway  
26 is a good example, no later than two years ago the  
27 Government officially stated that the Government would  
28 not proceed above sixteen years of age to furnish  
29 dental services and I think they had good and sufficient  
30 reason and it gets back to the statement that we made





1 this morning in respect to education. They now  
2 have reached a stage in the development of their welfare  
3 state where they are beginning to think more in terms  
4 of placing responsibility back on the individual instead  
5 of relieving the individual of responsibility.

6 COMMISSIONER FIRESTONE: But Dr. Gullett am  
7 I right in understanding some of the reasoning behind  
8 this which you have submitted to us, that you feel that  
9 making available comprehensive dental services in  
10 Canada is just not practical because you have not got  
11 the personnel to provide those services and furthermore,  
12 you feel that a good deal of it is wasteful because we  
13 could avoid a lot of these services by employing more  
14 common sense. I think this is your basic thinking but  
15 you have no objection to providing increased services  
16 to the Canadian people if more dentists can be made  
17 available?





1 DR. GULLETT: That question is just  
2 another way of saying the same thing to which I have  
3 replied, I think. We do not believe that it would be  
4 the proper thing to do, regardless.

5 COMMISSIONER McCUTCHEON: Haven't you  
6 said that in one sentence, Dr. Gullett, on page 46,  
7 paragraph 136?

8 DR. GULLETT: Yes.

9 COMMISSIONER FIRESTONE: Thank you,  
10 Mr. Commissioner, for drawing my attention to it. I  
11 was coming to paragraph 136; I am still at paragraph  
12 133.

13 I am sorry, I don't quite recall the  
14 last point that you made, Dr. Gullett.

15 THE CHAIRMAN: What Dr. Gullett said  
16 was - your question was just rephrased and he gave you  
17 the same answer as the previous one.

18 COMMISSIONER FIRESTONE: What I would  
19 like your views on - would you not feel that when we  
20 have reached the stage that we can perhaps afford to  
21 spend more money on dental services there should be a  
22 program of dental insurance?

23 DR. GULLETT: I don't believe that  
24 from the standpoint of economics it would be the thing  
25 to do.

26 COMMISSIONER FIRESTONE: Now, you say  
27 in paragraph 134 that if the Commission should recommend  
28 the establishment of a dental insurance plan you would  
29 recommend certain priorities be observed. Am I right  
30 in that understanding?







1 DR. GULLETT: Yes.

2 COMMISSIONER FIRESTONE: In other  
3 words, you are not in favour of a dental insurance  
4 plan but you say if there is popular demand for it and  
5 government wishes to proceed it should be practical  
6 enough to take account of the facts of life which you  
7 enumerate in these paragraphs?

8 DR. GULLETT: We would like to emphasize  
9 the word "if", and we would like to hope that the  
10 Commission will perhaps use something else to guide  
11 them besides pressure of the public, and what have you.

12 COMMISSIONER FIRESTONE: We are here  
13 to have your advice, and I take it paragraph 134 is an  
14 outline of the advice you are offering to this Commis-  
15 sion?

16 DR. GULLETT: Yes.

17 COMMISSIONER McCUTCHEON: Prefaced by  
18 "if".

19 COMMISSIONER FIRESTONE: Can I have  
20 your help in explaining paragraph 134a when you say  
21 that "The dental treatment program should be preceded  
22 by and accompanied with intensive dental health educa-  
23 tion programs"? How would you propose such intensive  
24 health dental care programs should be implemented, and  
25 I am asking the question within the narrow context of  
26 what the Federal Government could do, and we would like  
27 your advice as to what suggestions we could make to the  
28 Federal Government.

29 DR. GULLETT: The best program that we  
30 know is explained at considerable length in Appendix XII





1 of the brief, where it is stated that initially the  
2 great need is for trained directors in health units  
3 to carry on the educational program. The results from  
4 these programs and progress in this matter are excellent.

5 I would like, if it is suitable, Mr.  
6 Chairman, for Dr. Grainger, who is familiar with these  
7 programs, to speak of the results obtainable. Dr.  
8 Grainger has done an analysis and survey of these  
9 programs.

10 DR. GRAINGER: Well, sir, the actual  
11 change in the dental care is measurable statistically,  
12 and this can be tabulated, and there are published  
13 articles which are referred to in the brief, biblioc-  
14 graphy, which can be obtained for you.

15 But there are additional benefits  
16 which I think are more desirable, and these less tangible  
17 - I think a socialist, economist could actually measure  
18 it, and it is this sense - this is a democracy, and  
19 they can only function if people are all responsible  
20 for the country.

21 As teachers we must have people to  
22 teach themselves that they don't need help. In other  
23 words, if we merely say: "Who are you? We will pay  
24 all the costs of the trouble you get in" and never  
25 tell them how to keep out of trouble, it will never  
26 help them, and this is a field where there is so much  
27 that can be done by the individual and the benefit  
28 comes from this fact.

29 There shouldn't be anyone in Canada  
30 who can say: "I have never been told how I can reduce







1 my dental care", or they won't all do it. But there is  
2 a proportion of responsible citizens who do respond,  
3 and the whole acceptance of pre-treatment will be  
4 greater, rather than hand something out in a grab bag  
5 that people have never had before, won't appreciate.

6 COMMISSIONER FIRESTONE: Thank you  
7 for that explanation. I am just wondering where the  
8 Federal Government comes into this intensive dental  
9 health educational program.

10 DR. GULLETT: Well, the Federal Govern-  
11 ment comes in in the sharing of costs with the Provin-  
12 cial Government and the municipalities. But as I  
13 pointed out this morning, there needs to be more attrac-  
14 tion economically in order to put this program on its  
15 feet.

16 COMMISSIONER FIRESTONE: What kind of  
17 an attraction do you have in mind, sir?

18 DR. GULLETT: Well, the salary situa-  
19 tion for the type of man is not cognizant with practice,  
20 not through lack of enthusiasm but through lack of  
21 comparative income.

22 COMMISSIONER FIRESTONE: How can this  
23 situation be corrected?

24 DR. GULLETT: It can be corrected  
25 through the national health grants.

26 COMMISSIONER FIRESTONE: Are you then  
27 suggesting an increase in national health grants for  
28 that purpose?

29 DR. GULLETT: That is right.

30 COMMISSIONER FIRESTONE: Thank you.





1 I turn now to paragraph 134b, in which I understand  
2 you are putting a high priority on the treatment of  
3 children between the ages of three and sixteen; is  
4 that correct, sir?

5 DR. GULLETT: That is right.

6 COMMISSIONER FIRESTONE: And you have  
7 given us a schedule on Table I on page 43 how this can  
8 be achieved over a period of time. Now, if the Canadian  
9 government were to implement such a program of increased  
10 dental care service for children between the ages of  
11 three to sixteen along the lines mentioned in paragraph  
12 134b, have we got enough dentists to look after these  
13 children?

14 DR. GULLETT: You will see in the  
15 explanation of the plan that it is done by means of  
16 assessment. We have already done this in experiments.  
17 You have so many dentists in the health area, you have  
18 so many children, and the age group depends on the  
19 supply of personnel to some extent.

20 But what we have found is that with  
21 the introduction of a program in a health area your  
22 supply increases to take care of the program.

23 COMMISSIONER FIRESTONE: If Canada  
24 wanted to introduce a dental health program for children  
25 between the ages of three to sixteen, say, in three to  
26 four years, would we have enough dentists to take care  
27 of such a program?

28 DR. GULLETT: I doubt if we would. It  
29 would be a difficult program. But to introduce a  
30 program to take the children of three to sixteen - now,





1 in our presentation before the Federal Government  
2 Committee in 1943 or 1944 in connection with this  
3 matter, we said that, but it illustrates how ignorant  
4 we were, because we didn't know how many children we  
5 were talking about; we found out afterwards.

6 If you take too large a group of  
7 children into your program you bog down with the  
8 amount of treatment. Our contention is that it is  
9 better to start with the low age group and to adequately  
10 care for that child and then maintain that in a condi-  
11 tion of health.

12 If you take in the upper age groups  
13 of children you bog down the treatment that you never  
14 can continue with the care.

15 COMMISSIONER FIRESTONE: In paragraph  
16 c you say that: "Treatment should be provided by  
17 dentists in private practice". Could you visualize a  
18 program that could combine this provision of dental  
19 service by dentists in private practice with dental  
20 examinations in schools by dentists and treatment in  
21 dental clinics on an out-patient basis, as mentioned  
22 later on in your report?

23 DR. GULLETT: We believe that overall  
24 the best results will be obtained in quality of service  
25 through private practice. We make this statement  
26 knowing full well that there are circumstances perhaps  
27 where other arrangements of practice may become neces-  
28 sary.

29 But I think I should point out that  
30 we have made a study over a number of years of this







1 form of practice, and as was stated here yesterday by  
2 the doctor representing the paediatric clinic or centre,  
3 we have found out that it is very easy theoretically  
4 to lay down on paper great savings, but it doesn't  
5 work out in a practical way when you attempt to do it.

6 Now, up to the present time we believe  
7 that the private practice arrangement is best, and that  
8 is the arrangement we are carrying out in these health  
9 units, and it works satisfactorily.

10 COMMISSIONER FIRESTONE: How would  
11 such a plan work for families that cannot afford to  
12 pay for these dental services for children of ages 3  
13 to 5, say, the first age group, and then later on?  
14 How would this scheme work?

15 DR. GULLETT: Well, we have a recommen-  
16 dation in our report about the indigents, as you have  
17 observed; we think they should be covered. But I  
18 think I must tell you that in our private experimental  
19 plans we run into this difficulty.

20 I think it is interesting in the  
21 health unit they offered to pay money for these chil-  
22 dren. The intensified dental health program carried  
23 out by the director in the area was such that none of  
24 that money was ever utilized, because in the intensifi-  
25 cation the parents took pride in care for their children.

26 However, we think the indigents should  
27 be covered.

28 COMMISSIONER FIRESTONE: 134g, you say  
29 that "The plan should be administered by provincial,  
30 non-profit, profession-sponsored dental service





1 corporations which have representative lay as well as  
2 professional members on their boards of directors".

3 Now, let's assume, Dr. Gullett, that  
4 some provinces have a voluntary medical care plan and  
5 they have taken or they have designated as their agent  
6 one of the CAMSI/ACEMI organizations which has been  
7 active hitherto in the field of medical care services.







1 Could you visualize such a non profit, voluntary  
2 organization could act with one wing looking after  
3 medical services and another wing looking after dental  
4 services for children in the categories you have  
5 mentioned here, with dentists, physicians, and lay  
6 people participating, and perhaps some provincial  
7 government people, if they have set up this organization.  
8 Could one visualize one organization to look after  
9 health services, rather than several?

10 DR. GULLETT: Well, I believe in the statement  
11 by the poet that good fences make good neighbours, we  
12 have a type of program here which is different in  
13 approach than the customary medical service program.  
14 I think that the administration of the program is all-  
15 important, as to how it is carried out, and for that  
16 reason we believe that there should be, as stated here,  
17 a corporation with a board of lay representatives of  
18 the consumers, as well as the profession, who  
19 concentrate upon this type of promotion, which is  
20 essentially prevention and control.

21 Now, having said that there is room in the  
22 purely technical operation of the administration where  
23 we would not expect for instance to take members of  
24 the profession to do that part of the work. It would  
25 be a lay operation, but we would want to, for any  
26 combination of circumstances we would want to make  
27 sure that the control was such that the result would be  
28 achieved.

29 COMMISSIONER FIRESTONE: In other words, you  
30 are in favour, if I understand you correctly, of the





1 dental profession having a major say in how this  
2 program is carried out, but you wouldn't mind if the  
3 people, the administrative people, were in one building,  
4 under one corporate roof. Is this the correct  
5 understanding? If not, please put it in your own words,  
6 sir.

7 DR. GULLETT: I didn't say exactly that. I  
8 have a horrible fear of this idea of creating great  
9 administrative setups. This is one of the objections  
10 to the British scheme today. They have in Great  
11 Britain one administrator for every eight dentists  
12 that are practising, and to me that is a horrible  
13 thing. It means that there is so much money goes into  
14 the budget for dental services, and it is distributed  
15 among nine people, one of which does nothing to  
16 render any services under the scheme. I have a horror  
17 of these ideas of thinking of a great administrative  
18 setup. Bigness does not always accomplish the best.

19 COMMISSIONER FIRESTONE: Well, of course we  
20 are talking of provincial schemes, not a national  
21 scheme. On the assumption then that a national health  
22 program would be more efficiently operated if it were  
23 de-centralized, on that basis is it your answer that  
24 you would prefer to have a separate dental administration,  
25 separate and apart from any administration of a medical  
26 care plan?

27 DR. GULLETT: That is right, and I doubt very  
28 much if it would not be cheaper than doing it in the  
29 one big organization.

30 COMMISSIONER FIRESTONE: Fine sir. May I





1 now turn to paragraph 134 L on page 45, where you say  
2 that consideration should be given to the possibility  
3 of experience-rating municipalities. Does it mean  
4 that you are in favour that if such dental services  
5 were passed, applicable to children ages three to  
6 sixteen that the parents of children living in  
7 municipalities without fluoridation should pay more  
8 than the parents living in a city with fluoridation?

9 DR. GULLETT: We think that is a reasonable  
10 conclusion.

11 COMMISSIONER FIRESTONE: In the same paragraph  
12 you also suggest consideration of the possibility of  
13 placing deterrent taxes on non-essential food and  
14 beverages. Would this include, in your opinion, an  
15 increased sales tax on sugar?

16 DR. GULLETT: We didn't specifically mention  
17 sugar, although it is known that excessive ingestion  
18 of sugar causes dental caries. It is the carbo-  
19 hydrate content of the diet is the main offender, as  
20 everyone knows. We merely make the suggestion here  
21 that ways and means should be considered of cutting  
22 down the intake of these cariogenetic creation foods.

23 COMMISSIONER FIRESTONE: In other words,  
24 you are not necessarily in favour of increased sales  
25 tax on sugar?

26 DR. GULLETT: We say a possibility, yes.

27 COMMISSIONER FIRESTONE: Well, if you don't  
28 include sugar, what would you include? What would  
29 you consider under the heading non-essential foods?

30 DR. GULLETT: That is the main offender. It







1 is excess of sugar that does the damage.

2 COMMISSIONER FIRESTONE: Yes, but how do you att-  
3 ack the absence of sugar in your deterrent tax, because  
4 you are affecting also the minimum consumption to  
5 which you do not obje

6 DR. GULLETT: We realize that.

7 COMMISSIONER FIRESTONE: In paragraph 136,  
8 which my fellow Commissioner was so interested in, the  
9 reference is that the Canadian Dental Association  
10 stands resolutely opposed to the introduction of a  
11 comprehensive treatment program for people of all ages.  
12 Is your opposition to a comprehensive treatment program  
13 for people of all ages, does that mean that you have  
14 no objection to a partial program for people in the  
15 younger age group? I am just trying to understand  
16 the meaning of the word comprehensive and the meaning  
17 of the word all ages.

18 DR. GULLETT: We believe that a comprehensive  
19 treatment program should be carried out for the  
20 youngest age groups. We are of the opinion, and  
21 perhaps wrongly, that this can probably be done better  
22 by a voluntary plan of education than it will ever  
23 be accomplished through a compulsory plan. We  
24 come to this conclusion through comparison with what  
25 has gone on through other plans in other countries.

26 COMMISSIONER FIRESTONE: When you speak of  
27 a voluntary plan, do you refer to education only, or  
28 do you refer also to prepayment?

29 DR. GULLETT: Well, we are perfectly agreeable  
30 to prepayment, and it is in our policy, and we are





1     endeavouring to establish prepayment plans.

2                 COMMISSIONER FIRESTONE: So, do I understand  
3     from what you are saying that the Canadian Dental  
4     Association is in favour of a prepayment plan for  
5     dental services in Canada on a voluntary basis?

6                 DR. GULLETT: And for children.

7                 COMMISSIONER FIRESTONE: And for children.  
8     Now, if a group of people come to a life insurance  
9     company, or to a provincial dental association, and  
10    say could you work out for us people, people in  
11    different age groups, not just children, but adults  
12    as well as children, come to a provincial dental  
13    association and say to them, could you work out for us  
14    a plan similar to what is available in the medical  
15    field on a prepayment basis, voluntary, dentist-  
16    sponsored, what would be your views to such a request?

17                DR. GULLETT: Well, on the one hand we are  
18    talking about doing something for the whole nation, and  
19    I have been replying on that basis. Certainly for  
20    groups of people we have done a great deal of work in  
21    respect to prepayment, for taking in a group of  
22    employees, or something of that kind. Now, we can  
23    go part way with that sort of thing, but it is very  
24    difficult to talk about a national prepayment plan  
25    for all people and a plan for a certain stated group  
26    of people, and we are very anxious to have the  
27    experience in working in prepayment plans for groups  
28    of employees.

29                COMMISSIONER FIRESTONE: In other words, you  
30    are in favour of a partial prepayment plan?







1 DR. GULLETT: That is right.

2 COMMISSIONER FIRESTONE: But you feel that  
3 a national and comprehensive plan is not applicable,  
4 because you haven't got the resources but you feel  
5 that you have the resources to introduce a partial  
6 plan?

7 DR. GULLETT: A voluntary, prepaid.

8 COMMISSIONER FIRESTONE: If the dental  
9 resources are increased could that partial voluntary  
10 plan not be extended to the rest of Canada?

11 DR. GULLETT: Well, in the first instance I  
12 feel that that is so long ahead as far as our  
13 facilities and personnel are concerned that most of  
14 us sitting in this room do not need to worry about  
15 it at this stage, but there is not any question that  
16 if it became possible for a voluntary prepayment plan  
17 to function, that we would be favourable to it.

18 COMMISSIONER FIRESTONE: Applicable to the  
19 nation as a whole, provided there were adequate  
20 resources in terms of dentists, etc., available, that  
21 is your point?

22 DR. GULLETT: Yes.

23 COMMISSIONER FIRESTONE: The subject of  
24 fluoridation, paragraph 137 and 183. What are your  
25 views about the many ~~hundreds~~ and thousands of households  
26 that do not have access to communal water supply? What  
27 is the solution to their problem? This is largely  
28 our rural population?

29 DR. GULLETT: That is right. Unfortunately,  
30 until there is more research done we really haven't a





1 good answer. As everyone knows, there are propositions  
2 in respect to the use of tablets, and this sort of  
3 thing. Take for instance one point in connection with  
4 such a program. Parents may be enthusiastic with  
5 young children, and enter into this program whole-  
6 heartedly, and admittedly, while there is no  
7 scientific proof that it will have the same effect,  
8 there is reason to believe that it would have the  
9 same effect, if carried out faithfully. But this  
10 program must start before the child is born and be  
11 carried on until at least the age of twelve or  
12 fourteen years, and we are very doubtful as to how  
13 many parents would carry through a program of that  
14 nature for so long. So it makes it difficult to say  
15 that if you will do this you will get a certain  
16 result, because of the human frailties which enter  
17 into it.

18 COMMISSIONER FIRESTONE: Are any research  
19 results available, either in Canada or in other  
20 countries which would support the contention that the  
21 use of fluoridation tablets has been beneficial to the  
22 children?

23 DR. GULLETT: We know of no experiment on a  
24 scientific basis that has been carried out long enough,  
25 and for the same reasons it would be extremely  
26 difficult to carry it out.

27 COMMISSIONER FIRESTONE: This Commission has  
28 had groups that were for fluoridation, and groups that  
29 were against, and one of the arguments we have  
30 encountered from people speaking against fluoridation





1 has been this. Now, I am presenting this in a layman's  
2 way, so forgive me if it is not quite as scientific  
3 as you would present it, but my understanding was this,  
4 that dentists prescribe where fluoridation tablets  
5 are used, that only a limited number should be given  
6 to children. Now, this particular person suggested  
7 to us when a child drinks fluoridated water, you  
8 cannot control the quantity of water he consumes and  
9 therefore the suggestion was made to us that he  
10 may take in more fluoridation, or whatever there is  
11 in fluoridated water, than is good for his health.  
12 Now, what is the answer to this particular argument?

13 DR. GULLETT: Well, that does not occur.  
14 There is a wide margin there, in anything that would  
15 be injurious. That is one thing sure, and it just does  
16 not happen.

17 THE CHAIRMAN: A child can only drink so  
18 much water too, I suppose.

19 DR. GULLETT: That is right.

20 COMMISSIONER FIRESTONE: In other words, the  
21 dentists' observation is that no quantity of water a  
22 child may consume would be hurting the child, or  
23 affecting his health adversely in any way whatsoever.  
24 That is the considered opinion of your profession?







1 DR. GULLETT: If my memory holds good  
2 you would have to drink 400 glasses a day before you  
3 would reach a danger point.

4 COMMISSIONER FIRESTONE: I think that  
5 is a very good answer. May I now turn to paragraph  
6 139 in which you recommend that the Federal Government  
7 could pay 50% of these costs of fluoridation. Does  
8 this 50% refer to capital costs, to operating costs or  
9 to both?

10 DR. GULLETT: To both. The \$1,500,000  
11 is an estimate of capital costs which is given in  
12 paragraph 141.

13 COMMISSIONER FIRESTONE: Did I under-  
14 stand you correctly that the recommendation in paragraph  
15 139 refers to 50% of capital costs and operating costs?

16 DR. GULLETT: Yes.

17 COMMISSIONER FIRESTONE: May I now  
18 turn to paragraph 152 in which you commence to deal  
19 with treatment programs for public assistance. You  
20 mention that five provinces already have programs which  
21 provide dental service for some or all the people who  
22 are recipients of public assistance. What is the  
23 position for recipients of public assistance in the  
24 other five provinces?

25 DR. GULLETT: There is no program.

26 COMMISSIONER FIRESTONE: What happens  
27 if somebody suffers great pain and he has not got the  
28 money to pay the dentist and there is no public assis-  
29 tance program that provides him with such service? In  
30 these other five provinces what does he do?





1 DR. GULLETT: There is no dentist  
2 that refuses to relieve pain or suffering no matter  
3 whether they have money or not.

4 COMMISSIONER FIRESTONE: In other  
5 words, in such a case somebody would have to call up  
6 a dentist and say "Could I make an appointment, I  
7 have not got the money to pay for your services" and  
8 the dentist will say "Fine, come in and I will look  
9 after you". Is that the way it works?

10 DR. GULLETT: I think that is true.  
11 You may find exceptions but I think on the whole that  
12 is true.

13 COMMISSIONER FIRESTONE: Now, when you  
14 speak of public assistance you are referring here to  
15 what are called the indigent people on the public assis-  
16 tance rolls. Now, there are other people who are  
17 described as the medically indigent who are people that  
18 may be self-supporting but have lost their job and have  
19 a large family and cannot pay for medical or dental  
20 treatment. How are these needs taken care of?

21 DR. GULLETT: They are taken care of  
22 in private offices. You will note a recommendation  
23 further on where we are thinking in connection with  
24 out-patient clinics in hospitals which we think is  
25 something that should be done in order to take care of  
26 those people that fall in that area and we make that  
27 recommendation.

28 COMMISSIONER FIRESTONE: That is a  
29 very constructive recommendation and I will come back  
30 to it in a minute.







1 In paragraph 153 you recommend that  
2 the provinces institute dental treatment benefits for  
3 all beneficiaries of presently operating public assis-  
4 tance programs. That, I assume, means that the five  
5 provinces that do not have that program should insti-  
6 tute it; is that what it means?

7 DR. GULLETT: And in or two of the  
8 provinces it is only part of these people who are  
9 covered; in the Province of Ontario, it is only the  
10 children who are covered.

11 COMMISSIONER FIRESTONE: In other  
12 words, you are recommending full coverage?

13 DR. GULLETT: Full coverage.

14 COMMISSIONER FIRESTONE: Of all the  
15 indigent people that are now on public assistance rolls?

16 DR. GULLETT: That is right.

17 COMMISSIONER FIRESTONE: Would you  
18 extend that to the medically indigent? Would you  
19 extend these same recommendations in paragraph 153  
20 which applies to the indigent defined as people being  
21 on public assistance rolls, also to medical indigents?

22 DR. GULLETT: Well, we think it is  
23 perfectly true that falling in the category of a  
24 medical indigent there are cases where there should be  
25 subsidization by government. We believe that this  
26 should be done with some form of a means test comparing  
27 the man with one child and the man with ten children.  
28 We think it cannot be done on an income basis because  
29 there is a big difference there.

30 COMMISSIONER FIRESTONE: You are quite





1 right. Dr. Gullett, the way the scheme is worked at  
2 the present time it is based on a means test?

3 DR. GULLETT: That is right.

4 COMMISSIONER FIRESTONE: Would you  
5 recommend then that the means test be extended to the  
6 medically indigent who want the advantages of these  
7 services?

8 DR. GULLETT: Yes.

9 COMMISSIONER FIRESTONE: So your  
10 recommendation in paragraph 153 would on this basis  
11 extend to the medically indigent as well?

12 DR. GULLETT: Right.

13 COMMISSIONER FIRESTONE: May I now  
14 turn to paragraph 205 where you deal with the question  
15 of auxiliary services. You were very helpful to us in  
16 explaining that there were really three groups of auxi-  
17 liary personnel, you differentiated between the techni-  
18 cian, the assistant and the hygienist.

19 I take it that the hygienist is the  
20 only person that works in the mouth of the patient?

21 DR. GULLETT: And the only one receiving  
22 formal training.

23 COMMISSIONER FIRESTONE: Now, this may  
24 be a question addressed to a practising dentist and may  
25 be based on judgment rather than actual experience. I  
26 take it such hygienists, in order to be used more fre-  
27 quently, would have to work under the direct supervision  
28 of the dentist?

29 The way you visualize increasing the  
30 use is under supervision of a dentist?





1 DR. GULLETT: Under the instruction  
2 and supervision, yes.

3 COMMISSIONER FIRESTONE: Of a dentist?

4 DR. GULLETT: Yes.

5 COMMISSIONER FIRESTONE: Could a  
6 dentist look after two hygienists, for instance, in an  
7 office as well as practise himself?

8 DR. GULLETT: Scme do.

9 COMMISSIONER FIRESTONE: Would two or  
10 three be a practical number or would that be too much  
11 strain or would it dilute the supervisory capabilities  
12 of the dentist?

13 DR. GULLETT: Yes, I think under one  
14 dentist two would be a maximum. Now, the combination  
15 works well with one hygienist with one dentist.

16 COMMISSIONER FIRESTONE: If one had,  
17 for instance, offices and many more offices with one  
18 dentist and two hygienists and perhaps one assistant  
19 nurse to look after the telephone and billing and all  
20 the other details, how would this increase the producti-  
21 vity of this office?

22 That is to say, if you had a staff of  
23 two hygienists, one dentist and one assistant as against  
24 a dentist and an assistant.

25 DR. GULLETT: The productivity - this  
26 has been done with one dentist with two trained auxi-  
27 liaries ---

28 COMMISSIONER FIRESTONE: Two trained  
29 auxiliaries, meaning ---?

30 DR. GULLETT: It would take time to







1 get the details as to the type of auxiliaries but it  
2 has been carried out accurately in experimental work  
3 that a dentist with two trained auxiliaries can increase  
4 his productivity 66% which is a big item. This is one  
5 of the reasons why we support the extension of auxiliary  
6 services.

7 COMMISSIONER FIRESTONE: Have other  
8 countries had experience with increasing the use of  
9 auxiliaries in increasing productivity of dental  
10 services?

11 DR. GULLETT: Not to any great extent.  
12 The dental hygienist was developed in the United States  
13 at the beginning of 1919 and this has not been, if we  
14 want to criticize our own profession, I think the  
15 dental profession has been very slow to seize on the  
16 idea of auxiliaries.

17 COMMISSIONER FIRESTONE: Thank you  
18 very much. May I now turn to paragraph 219, out-patient  
19 dental clinics. You suggest that out-patient dental  
20 clinics should be established in public general hospi-  
21 tals especially to assist in improving the needs of  
22 marginal income groups.

23 By marginal income groups, do you  
24 mean what we have described earlier, the indigent and  
25 the medical indigent?

26 DR. GULLETT: This is a medical indi-  
27 gent.

28 COMMISSIONER FIRESTONE: Medically  
29 indigent?

30 DR. GULLETT: Yes.





1 COMMISSIONER FIRESTONE: Is there any  
2 special reason why you differentiate? Why would you  
3 keep the indigent, the people on public assistance, out  
4 of the clinic and would require the medically indigent  
5 to come into the clinic?

6 DR. GULLETT: No, except we have made  
7 a straight recommendation in respect to the public  
8 assistance groups that they should be paid for. Now,  
9 if such arrangements were made for subsidization of  
10 the marginal group or the medically indigent group  
11 then that would be taken care of too to some extent.  
12 We still believe that there would be need for the out-  
13 patient department in the hospital to handle the situa-  
14 tion.

15 This represents a problem which we  
16 have had particularly in the larger cities for years.

17 COMMISSIONER FIRESTONE: In paragraph  
18 220 you say:

19 "Dentists who have been accorded  
20 hospital staff privileges should  
21 provide service on a rotational  
22 basis and charges made to patients  
23 should be comparable to those assessed  
24 for other out-patient services".

25 Now, if the services are confined in  
26 the clinic to the medical indigent who cannot afford  
27 to pay, how are the dentists going to be paid?

28 DR. GULLETT: It is really under the  
29 control of the hospital, as you will understand. One  
30 of the good things about this arrangement is that the







1 hospital is qualified in a social way to judge these  
2 cases.

3 It does not mean all these people  
4 would pay but there are people who should pay, as you  
5 well know.

6 COMMISSIONER FIRESTONE: Now, looking  
7 at it purely from the dentist's point of view, as you  
8 know, out-patient clinics may, if the provinces so  
9 wish, the cost of such clinics may be shared by the  
10 Federal Government under the Hospital Insurance Program.

2 11 THE CHAIRMAN: You mean dental?

12 COMMISSIONER FIRESTONE: I am talking  
13 about out-patient clinics at the moment. Your sugges-  
14 tion would be to extend it to dental services. At the  
15 moment all the Act speaks of is out-patient clinic.

16 THE CHAIRMAN: Medical service.

17 COMMISSIONER FIRESTONE: This is, of  
18 course, a completely new suggestion and I was just  
19 going to go from here. Now, assuming that this would  
20 be extended not only as it exists now to medical  
21 services but also to dental services to cover your  
22 recommendation in paragraph 220, I presume the dentists  
23 would be paid for the services they render for this  
24 clinic?

25 DR. GULLETT: Well, we have this  
26 in operation in specific locations now in a limited  
27 way. Our contention is it should be extended.

28 COMMISSIONER FIRESTONE: The dentists  
29 would, therefore, receive a salary for part-time work  
30 done at the hospital, is that correct?





1 DR. GULLETT: It is done both ways.

2 COMMISSIONER FIRESTONE: I just want  
3 to know what your recommendation means. Paragraph 220,  
4 I take it, dentists were providing a service on a  
5 rotational basis two hours a week and presumably they  
6 would be paid for their two hours a week.

7 DR. GULLETT: They are not all in  
8 the hospitals. There are some full-time dentists in  
9 the hospitals who are paid, there are other situations  
10 where dentists serve in the out-patient department with  
11 no payment whatsoever.

12 COMMISSIONER FIRESTONE: What I am  
13 trying to obtain is whether this recommendation in  
14 paragraph 220 envisages payment for the services  
15 which the dentist will be providing on a rotational  
16 basis in out-patient clinics?

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1 DR. GULLETT: I think the wording of this  
2 Dr. Firestone is meant to conform with hospital  
3 practice and after all there is some variation in the  
4 way that the hospitals conduct their out-patient  
5 clinics and that is all that is meant by the wording  
6 there and the dental profession would conform to  
7 hospital practice the same as other departments I  
8 think it says.

9 COMMISSIONER FIRESTONE: I take it then if  
10 hospitals pay physicians for services rendered on a part-  
11 time basis, dentists would want to be treated the same  
12 way?

13 DR. GULLETT: We are not asking for anything  
14 that is not the custom within the hospital at the  
15 present time.

16 COMMISSIONER FIRESTONE: In other words, you  
17 have no objection, dentists have no objection to being  
18 paid a salary on a part-time basis for work performed  
19 at a hospital?

20 DR. GULLETT: No.

21 COMMISSIONER FIRESTONE: Thank you.

22 THE CHAIRMAN: Thank you very much, Dr.  
23 Gullett and Miss Boyd and associates. Dr. Strachan  
24 expressed on behalf of the Commission this morning  
25 our appreciation for the very fine brief; complete  
26 and helpful brief and I want to join Dr. Strachan in  
27 that.

28 COMMISSIONER STRACHAN: I wonder if any of  
29 the group has anything further to add Mr. Chairman?

30 THE CHAIRMAN: They have the floor.







1 DR. MILLER: May I on behalf of the  
2 Canadian Dental Association thank the Commission for  
3 the privilege of appearing before them and also for  
4 your kindness and consideration and for the great  
5 interest that you have taken in dental health matters.  
6 Thank you very much.

7 MR. HALL: The next submission is by the  
8 Canadian Arthritis and Rheumatism Society. I would  
9 ask that their brief be filed as Exhibit 194.

10 ---EXHIBIT NO. 194: Submission by The Canadian  
11 Arthritis and Rheumatism Society.

12 APPEARANCES: Mr. J.M. Macintosh  
13 Dr. Wallace Graham  
Mr. Edward Dunlop.

14 MR. HALL: Presenting the submission of the  
15 Society is the National Vice President, Mr. J.M.  
16 Macintosh who has prepared a summary of the main brief  
17 which I would ask him to present at this time.

18 MR. MACINTOSH: Mr. Chairman, and members of  
19 the Commission: Our President Mr. C.M. King regrets  
20 that a long standing commitment off shore keeps him  
21 from presenting this brief to the Commission.

22 I had hoped that Mr. Twaits who is our Vice  
23 Chairman might have been able to present the brief.  
24 He is also out of Canada. Both Mr. King and Mr. Twaits  
25 have had a very much longer and more extensive experience  
26 with the Society but I am fortunate in having with me  
27 Dr. Wallace Graham who is Associate Professor of  
28 Medicine at the University of Toronto, who is Chairman  
29 of our National Medical Advisory Board, and by Edward  
30 Dunlop, who is the Executive Director of the Society.





1 I wish to be relatively brief in outlining  
2 the main features of the submission made by The  
3 Canadian Arthritis and Rheumatism Society, because I know  
4 that it has been studied by the Commissioners in advance  
5 of this hearing, and because I know that they recognize  
6 that the importance of a particular health problem --  
7 and the methods proposed for its solution -- is not  
8 to be judged by the length of time taken for its  
9 presentation.

10 (INTRODUCTION - Page 1, paragraphs 1 to 4).

11 I wish to refer to the introduction to our  
12 submission which begins -- quite appropriately -- on  
13 page 1. In turn, this refers to 3 appendices. It  
14 is sufficient to say, I think, that the first of these  
15 (Appendix "A") makes it clear that the various forms  
16 of arthritis and the other rheumatic diseases are a  
17 complex and variable group of disorders about which it  
18 is extremely difficult to generalize in terms of their  
19 diagnosis and treatment. Their single common  
20 characteristic is that they involve connective tissues  
21 -- those tissues which give the body its shape, strength,  
22 elasticity and mobility, and which pervade all organs  
23 for the purpose of holding them together -- a purpose  
24 of not inconsiderable importance when it is recognized  
25 that without these connective tissue our bodies would  
26 be nothing more than a vast number of unsupported cells.  
27 Beyond this, and in some way as yet dimly perceived,  
28 the connective tissues play an important role in the  
29 processes by which the body becomes subject to  
30 disease, protects itself against disease, and applies







1 genetically impressed lessons of so many millions  
2 of years of evolution. I mention all this to stress  
3 two points which we think to be of great importance:

4 1. Relatively recent scientific  
5 advances have made it clear that  
6 various forms of arthritis and  
7 rheumatism are not -- as our  
8 fathers and grandfathers supposed --  
9 an unrelated group of aches and  
10 pains, but rather, that they are a  
11 grouping of the disorders of a  
12 fundamental bodily system, much in  
13 the same way that we understand the  
14 rational relationship which exists  
15 among the disorders of other major  
16 bodily systems, such as the cardio-  
17 vascular, nervous and endocrine  
18 systems. It is in this relatively  
19 recent recognition that we find so  
20 many of the exciting prospects for  
21 beneficial results through intensified  
22 research.

23 2. Although the means of prevention and  
24 specific cure for many of the common  
25 and serious forms of arthritis and  
26 other rheumatic diseases remain  
27 unknown, it is important to emphasize  
28 that through early diagnosis and the  
29 prompt and sustained application  
30 of measures of treatment already known





1 to medical science, serious  
2 disability can be prevented in a  
3 majority of patients. Your study of  
4 this Appendix will have informed you  
5 that some forms of arthritis and  
6 the other rheumatic diseases present  
7 more serious problems than others,  
8 and that even the most dangerous of  
9 these diseases may exist in mild,  
10 moderate and severe degrees. When  
11 we say that serious disability can  
12 be prevented in a majority of  
13 patients, we are referring particularly  
14 to those patients suffering from the  
15 potentially most devastating form of  
16 these diseases -- rheumatoid arthritis.

17 The second of these appendices (APPENDIX "B"),  
18 makes it clear that arthritis and the other rheumatic  
19 diseases are a major health problem because of their  
20 widespread incidence, and because of the disability,  
21 suffering, social and economic loss which they cause.  
22 The figures are before you in the appendix, and I need  
23 say no more.

24 APPENDIX "C" sets out the data relating to  
25 the organization, modus operandi and personnel presently  
26 engaged in the work of the Society.

27 The central core of our entire submission is  
28 to be found in paragraph 3. We are convinced, both  
29 through experience and careful observation, that an  
30 effective plan to control the ravages of arthritis and





1 the other rheumatic diseases can be quickly instituted.  
2 This program would not involve vast expenditures of  
3 public funds, yet we are convinced that its  
4 implementation would result in a prompt reduction in  
5 the extent and severity of crippling disability and  
6 deformity and, well within the lifetime of most of  
7 those in this room, lead to the ultimate conquest of  
8 these diseases.

9 The summary of the main recommendations are  
10 contained in paragraphs 5 and 6. The Canadian  
11 Arthritis and Rheumatism Society believes that an  
12 effective program for the control of arthritis and  
13 the other rheumatic diseases -- a program which would  
14 lift much of the burden of suffering -- could be  
15 achieved through the implementation of its main  
16 recommendations. The first of these specific  
17 recommendations is for the establishment of some 25 to 30  
18 rheumatic disease units, having some 30 to 40 beds each,  
19 at a total new cost of about \$1,250,000 by the year  
20 1970. The second is for the expanded governmental  
21 support of arthritis research, to reach a level of about  
22 \$875,000 by the year 1970. Our third main  
23 recommendation refers to the development of sufficient  
24 numbers of trained personnel, a proposal not  
25 specifically related to the control of arthritis and the  
26 other rheumatic diseases, but which seeks to emphasize  
27 trained personnel as the sine qua non of improved health  
28 care. These specific recommendations are amplified  
29 later in our brief and in section B, page 7, paragraphs  
30 13 to 19, and section J, page 22, paragraphs 51 to 60.







1 I shall discuss these recommendations more fully when  
2 I reach those sections of the brief.

3 Our other recommendations are of a subsidiary  
4 character, not necessarily related specifically to  
5 arthritis and the other rheumatic diseases. They deal  
6 with a number of matters affecting the diagnosis,  
7 treatment and rehabilitation of sick persons generally,  
8 particularly the chronically ill. We have offered  
9 these recommendations because we believe that the  
10 better the state of medical care generally, the better  
11 will be the state of medical care for patients suffering  
12 from arthritis and the other rheumatic diseases, and  
13 because we believe that our experience has been  
14 sufficient to demand that we make available to the  
15 Commission the conclusions we have drawn from it.

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(Term of Reference - "A" - THE EXISTING FACILITIES AND  
METHODS FOR THE PROVISION OF  
PERSONAL HEALTH SERVICES.  
Page 3, Paras. 7 to 10)

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In Section "A" (Page 3), we have pointed out that personal health services are provided to those suffering from arthritis and the other rheumatic diseases in the same way that they are provided for sick members of the community generally. We recognize that the general practice of medicine is a foundation upon which all other health services must be erected, and without which they could not stand. We believe this system to be the proper one, and the one which holds the greatest promise for ultimate success. We also recognize that the system has certain defects - the quite natural product of past events controlled by men and communities who could not be omniscient - and we subsequently, and in all humility, make proposals which we are persuaded will remedy these defects.

(Term of Reference "B" - METHODS OF IMPROVING EXISTING  
HEALTH SERVICES. Page 6,  
Paras. 11 to 29)

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In Section "B", we come to one of the Society's two main recommendations having to do with arthritis and the other rheumatic diseases specifically. It is a recommendation for a progressive establishment of rheumatic disease units until about 25 such units have been established by the year 1970. Because of the central importance of this recommendation to our whole submission, and because I can do no better, I ask your indulgence, Mr. Chairman, in allowing me to quote verbatim paragraphs 13 to 16.







1 13. "It is recommended that rheumatic  
2 disease units be established within  
3 the Departments of Medicine in some  
4 25 to 30 selected and well distributed  
5 major general hospitals. The design  
6 of each rheumatic disease unit will  
7 vary quite considerably according to  
8 the resources available, or which can  
9 be made available. In some cases,  
10 for example, 30 or 40 beds might be  
11 assigned to the rheumatic disease  
12 unit in a large general hospital,  
13 whereas in other cases, only 7 or 8  
14 beds might be assigned to the rheumatic  
15 disease unit at the general hospital,  
16 supplemented by additional designated  
17 beds, suitably staffed and equipped,  
18 at an associated chronic disease or  
19 convalescent hospital.

20 14. The proposed rheumatic disease  
21 units would be focal points for  
22 specialized diagnosis and treatment,  
23 research, and undergraduate, graduate  
24 and continuing medical education.  
25 The degree of emphasis upon these  
26 several activities would vary as  
27 between rheumatic disease units, and  
28 not all could carry a full program.  
29 Major research expenditure, for  
30 example, should be restricted to 4 or





1 5 selected units, the remainder under-  
2 taking a smaller volume of research.  
3 15. These units would also provide  
4 for the diagnosis, treatment, and  
5 rapid and orderly disposition of  
6 unusual or difficult cases. Patients  
7 should be admitted to or retained in  
8 these units only so long as they  
9 cannot be efficiently treated in other  
10 hospitals, their own homes and other  
11 less expensive facilities. Experience  
12 has shown that arthritis patients,  
13 even those suffering from severe disa-  
14 bility of long standing, make excellent  
15 progress under the intensive and segre-  
16 gated treatment provided in such units.  
17 16. By demonstrating the highest  
18 standards of diagnosis and treatment,  
19 by stimulating research, and through  
20 their educational activities, these  
21 rheumatic disease units would exercise  
22 a profound and beneficial influence  
23 on the care of arthritic patients,  
24 far beyond the confines of the units,  
25 and thus further contribute to a signi-  
26 ficant reduction in the incidence and  
27 severity of permanent physical disabi-  
28 lity".

29 Without discussing them further, I  
30 should like to ask the Members of the Commission to pay







1 particular attention to the footnotes relating to this  
2 section of our submission, particularly those which  
3 illustrate that the length of the patient stay in a  
4 rheumatic disease unit is not so unconscionable as  
5 sometimes might be thought, and one showing the  
6 striking success achieved last year by the University  
7 of Toronto Rheumatic Disease Unit. These satisfactory  
8 results are not unique, and have been repeated many  
9 times in many similar settings in many different  
10 countries.

11 Our subsidiary recommendations regarding  
12 the care of the chronically ill generally (Paras.  
13 20 to 28), contain ideas which we hope the Commission  
14 will find to be useful and important, but they are  
15 before you, and I shall not comment on them further.

16 Our subsidiary recommendations regarding  
17 the extension of health care insurance (Paras.  
18 29 to 31), relate to a matter of such evident public  
19 interest that I feel we must make some comment on them.  
20 In recommending that government funds should be applied  
21 to the subsidization of health care insurance for  
22 those not able to provide themselves with such insurance  
23 -- by reasons of age, state of health, the hazardous  
24 nature of occupations, geographical isolation or economic  
25 status -- the Society realizes that the Commission  
26 will not find this to be a novel proposition. The  
27 words which I am about to use seem subject to some  
28 degree of varying interpretation, but I am sure that  
29 the Commissioners will know what I mean when I say that  
30 the Society is not recommending a system of universal







1 or compulsory health care insurance, and that it is  
2 not recommending any form of universal or compulsory  
3 sickness cash benefit insurance program. We have taken  
4 this position for reasons which -- to us -- seem simple  
5 and obvious.

6 Mr. Chairman and Members of the  
7 Commission: The development of the "best possible  
8 health care for Canadians" - (I am quoting from P.C.  
9 1961-883), is an objective with which few will quarrel,  
10 but the attainment of which will make massive demands  
11 on the public purse. Recognizing that the citizen  
12 both consumes and finances health care services, we  
13 believe there are limits upon expenditure which are  
14 determined by the judgment of responsible government,  
15 and beyond which those governments will not go. We  
16 recognize that these limits change with the passage of  
17 time and the changing attitude of the public, but we  
18 greatly fear that the inauguration of a universal  
19 compulsory medical care insurance program at this time  
20 would consume all the funds which governments are likely  
21 to place into service of health, and consume them  
22 almost entirely for the purpose of paying for doctors'  
23 services. We perceive many needs which should be met  
24 before the bulk of available public funds is consumed  
25 in that particular fashion. The crucial needs are a  
26 sufficiency of hospital beds, an adequate supply of  
27 well trained personnel, and the development of rehabili-  
28 tation facilities. We would like first to be sure that  
29 the chronically ill, both the physically ill and the  
30 mentally ill, can be housed, diagnosed and treated in a





1 manner which will give them some hope of restoration  
2 to health or optimum functional capacity. We believe,  
3 Mr. Chairman, in what we regard as first things first.  
4 We know that there are special needs to be met to  
5 provide properly for the care of the arthritic and  
6 rheumatic, and we judge that there are similar general  
7 and special needs which must be met to provide the  
8 proper care of sick members of the community generally.  
9 We believe that many of these needs should be met  
10 before consideration is given to any extension of  
11 medical care or health care insurance. When health  
12 care insurance is to be extended, we believe first that  
13 governmental funds should be used to meet the needs of  
14 those who cannot insure themselves.

15 (Term of Reference "C" - CORRELATION OF NEW OR IMPROVED  
16 PROGRAMS WITH EXISTING SERVICES  
17 WITH A VIEW TO THE PROVISION  
OF IMPROVED HEALTH SERVICES.  
Page 14, Paras. 32 to 34)

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18 Our recommendations with respect to  
19 correlation are mainly concerned with our recommenda-  
20 tions relating to the care of the chronically ill  
21 generally. So far as our main recommendation is  
22 concerned -- that of the establishment of rheumatic  
23 disease units -- a reasonable degree of correlation  
24 will follow automatically from the location of these  
25 units at or in association with main regional general  
26 hospitals.

27 (Term of Reference "D" - FUTURE REQUIREMENTS OF PERSON-  
28 NEL TO PROVIDE HEALTH SERVICES  
Page 15, Paras. 35 to 38)

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29 The Canadian Arthritis and Rheumatism  
30 Society is convinced that an adequate supply of well







1 trained personnel is essential, and recognizes that  
2 all professional and skilled personnel serving in the  
3 cause of health play some part, greater or smaller, in  
4 the protection of the public against the ravages of  
5 arthritis and the other rheumatic diseases. Its  
6 special experience has caused it to become aware of  
7 the requirements in four groups: rheumatologists,  
8 physiatrists, physiotherapists and occupational thera-  
9 pists.

10                   The Society believes that, through  
11 its own fellowship program and otherwise, a sufficient  
12 supply of rheumatologists to man the proposed rheumatic  
13 disease units and provide other necessary services can  
14 be developed by 1970. It holds that the most important  
15 factor to be considered in ensuring a sufficient supply  
16 of well trained rheumatologists will be the reasonable  
17 assurance that rheumatic disease units will be established  
18 at settings in which they can find professionally  
19 rewarding careers. The Society feels that much the  
20 same is probably true of physiatrists as well. Although  
21 there is a definite shortage of physiatrists, it is  
22 hoped that reasonably laid plans for the development of  
23 rehabilitation facilities and the appointment of physia-  
24 trists to hospital staffs will generate the numbers  
25 required.

26                   The Society looks with anxiety at the  
27 loss to Canada of trained scientists and clinicians  
28 who must seek in other countries a setting to which  
29 they can apply their skills. The Society is also  
30 alarmed by the shortage of physiotherapists and





1 occupational therapists. Even the most conservative  
2 forecast, such as that in the Canadian Hospital Associa-  
3 tion's survey referred to in a footnote attached to  
4 this section, indicates that the demand for physio-  
5 therapists and occupational therapists will increase  
6 rapidly. We are convinced that this is a matter of  
7 great urgency, which must be tackled by what is often  
8 called (in other circles) a "crash program".

9 (Term of Reference "E" - METHODS OF PROVIDING ADEQUATE  
10 PERSONNEL WITH THE BEST  
11 POSSIBLE TRAINING AND QUALIFI-  
CATIONS FOR SUCH SERVICES  
Page 17, Paras. 39 to 42)

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12 The Society will not comment on  
13 training generally, as we believe this is a matter  
14 best dealt with by the appropriate professional and  
15 academic institutions and associations. I should like,  
16 however, to comment on the role which the proposed  
17 rheumatic disease units can play in medical education.  
18 Here again, Mr. Chairman, I ask your indulgence in  
19 quoting directly from our brief:

20 40. "Under present conditions, many  
21 medical students have limited oppor-  
22 tunities to observe the management of  
23 arthritis and the other rheumatic  
24 diseases. This is because arthritic  
25 and rheumatic patients are seldom  
26 retained in teaching units for suffi-  
27 ciently long periods, and this is  
28 further complicated by the frequent  
29 lack of continuity in the clinical  
30 responsibilities of medical students.





1 This lack of opportunity to observe  
2 the management of arthritis and the  
3 other rheumatic diseases creates a  
4 situation in which many medical  
5 graduates fail to recognize that  
6 these diseases respond favourably to  
7 good management. It is held that the  
8 establishment of rheumatic disease  
9 units, and other facilities for the  
10 care of the chronically ill, in  
11 settings where undergraduate and gradu-  
12 ate medical education is carried out,  
13 will have the most salutary long-term  
14 effect on this aspect of medical  
15 education.

16 41. It is also held that the estab-  
17 lishment of rheumatic disease units  
18 will make a most important contribu-  
19 tion to the continuing medical educa-  
20 tion of practising physicians".  
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1 (Term of Reference "F" - PRESENT PHYSICAL FACILITIES  
2 AND THE FUTURE REQUIREMENTS FOR THE PROVISION OF  
ADEQUATE HEALTH SERVICES. Page 18, paragraph 43).

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3 So far as physical facilities are concerned  
4 (paragraph 43), the Society believes that its main  
5 recommendations can be implemented within the framework  
6 of existing ratios and standards respecting physical  
7 facilities, provided only that these ratios and  
8 standards are progressively achieved.

9 (Term of Reference "G" - EXISTING COSTS OF HEALTH SERVICES  
10 NOW BEING RENDERED TO CANADIANS WITH PROJECTED COSTS OF  
ANY CHANGE WHICH MAY BE RECOMMENDED. Paragraph 19,  
paragraph 44 to 48).

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11 For the reasons set forth on page 19, Mr.  
12 Chairman, the Society has -- quite properly, we believe  
13 -- restricted its estimates of costs to those of its  
14 recommendations which are specifically applicable to  
15 arthritis and the other rheumatic diseases. In our  
16 view, these recommendations can stand alone, and  
17 their implementation would produce an effective arthritis  
18 control program regardless of the introduction of any  
19 other measures. I qualify this only to the extent of  
20 saying that our specific recommendations could hardly  
21 be carried out in the absence of trained personnel.  
22 The program which we propose would cost an estimated  
23 \$2,125,000 by the year 1970, this providing both for  
24 the establishment of the desired number of rheumatic  
25 disease units, and for what we judge to be a satisfactory  
26 volume of government financed arthritis research. We  
27 submit that this would be a modest expenditure in light  
28 of the benefits we are certain it would confer upon the  
29 Canadian people and economy.  
30





1 (Term of Reference "H" -- METHODS OF FINANCING HEALTH  
2 CARE SERVICES AS SPONSORED BY MANAGEMENT, LABOUR,  
3 PROFESSIONAL ASSOCIATIONS, INSURANCE COMPANIES OR IN  
4 ANY OTHER MANNER, Page 21, paragraph 49).

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5 We have no comment to offer with respect to  
6 financing of health services by the groups and  
7 organizations referred to in Section "H". (Page 21).

8 (Term of Reference "I" -- THE METHODS OF FINANCING ANY  
9 NEW OR EXTENDED PROGRAMS WHICH HAVE BEEN RECOMMENDED.  
10 Page 21, paragraph 50).

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11 The Society recommends that the proposed  
12 new rheumatic disease units be financed through a  
13 modest extension of existing hospital insurance  
14 programs as now sponsored by governments. Some part  
15 of this cost might be recovered through existing or  
16 extended health care insurance programs. We recommend  
17 that expanded arthritis research should be financed  
18 through consolidated revenues of the Government of  
19 Canada.

20 (Term of Reference "J" -- RELATIONSHIP OF EXISTING AND  
21 ANY RECOMMENDED HEALTH CARE PROGRAMS WITH MEDICAL  
22 RESEARCH AND THE MEANS OF ENCOURAGING A HIGH RATE OF  
23 SCIENTIFIC DEVELOPMENT IN THE FIELD OF MEDICINE IN  
24 CANADA. Page 22, paragraphs 51 to 60).

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25 In the important realm of research, Mr.  
26 Chairman, the Society submits (commencing at paragraph  
27 51) that there must be a strong general foundation upon  
28 which specialized research activities can be erected.

29 We also seek to stress a point which is all  
30 too often overlooked; that major discovery is not the  
sole objective of medical research. In paragraphs 53  
and 54 we have sought to show that medical research  
is the essential tool whereby standards of patient  
care may be improved. While the proposition has not







1 received widespread recognition, possibly due to the  
2 fascination which major discovery holds for the  
3 readers and writers in the popular press, I feel sure  
4 that this point is fully recognized by the  
5 Commissioners.

6 We submit, Mr/ Chairman, that governmental  
7 support for medical research can no longer remain a  
8 matter of passive approval of projects submitted by  
9 investigators. To this must be added positive  
10 encouragement for good research aimed at those diseases  
11 which are the leading causes of death and disability.  
12 In paragraph 55, we recommend that this concept should  
13 be entrenched in legislation. The funds required for  
14 the governmental support of arthritis research should  
15 reach about \$875,000 by 1970. This estimate is based  
16 on the judgment of our medical advisers, after  
17 extensive study, as to the personnel and facilities  
18 which could be made available, and the extent of the  
19 investigations which are justified having regard  
20 to the present state of knowledge. In light of what  
21 they regard as well informed forecasts, our research  
22 advisers are prepared to make estimates covering the  
23 next eight years. Beyond that time, they consider  
24 forecasts would be a matter of conjecture, rather  
25 than judgment.

26 We submit that our last point to do with  
27 research is one of major importance. In the planning  
28 and administration of government financed medical  
29 research in Canada we sense the existence of an  
30 unwritten policy which may be expressed in this way:





1 as there is too little money to finance medical  
2 research generally, if there is a voluntary agency  
3 interested in a special field, let them pay for it.  
4 We believe that this principle is wrong, for reasons  
5 cited in paragraph 60 of our submission.

6 (Term of Reference "K" -- FEASIBILITY AND DESIRABILITY  
7 OF ASSISTANCE OF PRIORITIES IN THE DEVELOPMENT OF HEALTH  
8 CARE SERVICES. Page 25, paragraph 61).

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8 We have now reached the question of priorities.  
9 The views of the Canadian Arthritis and Rheumatism  
10 Society are stated in paragraph 61. For the last time,  
11 Mr. Chairman, I ask your indulgence so that I may quote  
12 from our brief:

13 "61. In many well informed  
14 quarters, it has been said that the  
15 chronic diseases are, in the Western  
16 World at least, the greatest  
17 challenge facing medicine in the  
18 second half of the twentieth century.  
19 The prolongation of life, which has  
20 been brought about by medical  
21 science's increasing ability to  
22 master acute and epidemic illness, is  
23 contributing to the increasing  
24 prominence of the chronic diseases  
25 in the medical spectrum. It is  
26 recommended that any system of  
27 priorities should have regard for  
28 this trend, and should not condemn  
29 the victims of lingering illness --  
30 which often rob the body of its





1 essential vitality without taking  
2 life itself -- to a continued position  
3 of secondary concern in the planning  
4 and execution of health services.

5 Beyond this humanitarian consideration,  
6 The Canadian Arthritis and Rheumatism  
7 Society believes that efforts to  
8 overcome the ravages of chronic  
9 disease should receive a very high  
10 priority, because of the promise this  
11 holds for alleviating the nation's  
12 burden of pain, suffering and economic  
13 loss."

14 (Term of Reference "L" - SUCH OTHER MATTERS AS THE  
15 COMMISSIONERS DEEM APPROPRIATE FOR THE IMPROVEMENT  
16 OF HEALTH SERVICES TO ALL CANADIANS. (Page 25,  
paragraph 62 to 65).

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17 Our last words come under the heading of  
18 "Such other matters as the Commissioners may deem  
19 appropriate for the improvement of health services to  
20 all Canadians", and I hope it will not seem impertinent  
21 that we have offered some opinions in this realm,  
22 one which -- by definition -- is not open to us. The  
23 Canadian Arthritis and Rheumatism Society has felt it  
24 necessary, however, to offer some comments with  
25 respect to the role to be played by voluntary agencies.  
26 Although this is a subject which could occupy several  
27 books, we have limited our comments to three paragraphs.

28 Mr. Chairman, we believe we have presented  
29 a convincing brief. We believe that a very few years will  
30 see governments taking the action and providing the funds







1 necessary to lift the burden of rheumatic diseases  
2 from the people of Canada.

3 THE CHAIRMAN: Thank you very much, Mr.  
4 Macintosh, for the nature of your brief and the manner  
5 of presentation.

6 COMMISSIONER BALTZAN: I endorse exactly  
7 what you said, Mr. Chairman, and I thank you  
8 gentlemen, and I have no specific question, because I  
9 am thoroughly acquainted with the subject matter  
10 that is your problem.

11 I would only ask you one question on a  
12 definition, and that is to you, Dr. Graham. The use  
13 of the word physiatrists. Is that synonymous with  
14 the doctor of medicine participating in the field  
15 of physical medicine?

16 DR. GRAHAM: Yes, he is usually the  
17 supervisor of the physiotherapists, and so on, and is  
18 getting closely attached to the rehabilitation  
19 situation.

20 THE CHAIRMAN: I think one might say to you,  
21 Mr. Macintosh, Mr. Dunlop and Dr. Graham, that the  
22 concluding statement about this question of priorities  
23 is one that will find a responsive chord as we  
24 embark upon our deliberations, because this field is  
25 one of which we all appreciate the extent and the  
26 necessity for research and the other recommendations  
27 you have made.

28 These twenty or twenty-five units, you  
29 would have them dispersed over the whole of the  
30 country I take it?





1 MR. MACINTOSH: Yes, I think that is right,  
2 yes.

3 THE CHAIRMAN: Or would you attach them  
4 to the areas where medical education is being carried  
5 on?

6 DR. GRAHAM: If possible sir. We have  
7 estimated for the Canadian hospital survey that we  
8 would require something like a thousand to fifteen  
9 hundred beds, and if you put a unit of 25 to 30  
10 beds, and 25 of those would supply what we feel to  
11 be an adequate number of beds for the management,  
12 and we hope the correction of these people, associated  
13 if possible, not always with universities, this could  
14 not be of course, but in a setting where there could  
15 be post graduate training and so on.

16 MR. DUNLOP: The mathematics are a little  
17 defeating. With twelve universities and twenty-five  
18 training units, thirteen of them would have to be  
19 left with a little less close association.

20 THE CHAIRMAN: I am talking geographically  
21 still, within the area served by a medical school.

22 DR. GRAHAM: Yes sir. One does not like to  
23 take the chronic patient too far away from home, ever.

24 THE CHAIRMAN: What do you mean by that, Dr.  
25 Graham? Say he is living at Fort William?

26 DR. GRAHAM: Well, obviously there will be  
27 thirteen that are not in the university centres, and  
28 the head of the lakes will certainly be one of our ---

29 THE CHAIRMAN: I just mentioned that as  
30 being a long distance from any known medical school.







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1 DR. GRAHAM: Yes, some words from the...

2 THE CHAIRMAN: Thank you and for the...  
3 thank you for waiting. I know you have...  
4 end of the day it does not mean that the...  
5 won't receive exactly the same...  
6 have got in the morning.

7 We will recess until...  
8 the submission of the Royal College of...  
9 and Surgeons.

10 ---Adjourned.

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